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HOSPITAL PROFITS UNDER THE PROSPECTIVE PAYMENT SYSTEM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

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HOSPITAL PROFITS UNDER MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

FRIDAY, FEBRUARY 21, 1986

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:35 a.m., in room SD-215, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senators Durenberger, Heinz, and Baucus.

[The press release announcing the hearing and opening statements of Senators Durenberger and Packwood and a background paper prepared by the staff follows:]

[Press Release No. 86-003]

FINANCE SUBCOMMITTEE TO EXAMINE HOSPITAL PROFITS UNDER PPS

The profits realized by American hospitals under the Medicare Prospective Payment System (PPS) will be the subject of a hearing before the Senate Committee on Finance's Subcommittee on Health, Chairman Bob Packwood (R-Oregon) announced today.

Senator Packwood said the PPS hearing would begin at 9:30 a.m., Friday, February 21, 1986, in Room SD-215 of the Dirksen Senate Office Building in Washington.

He explained the Subcommittee on Health would review the financial status of the nation's hospitals under the new prospective payment system, which is generally recognized by its acronym, PPS.

The Chairman said the hearing is to begin with the presentation of a recent report from the Department of Health and Human Services' Inspector General. The report indicates that hospitals receiving prospective Medicare payments had record profits during the first year of the new payment system. The Inspector General's study found that hospitals in nine states reported an average profit of over 14 percent on Medicare payments.

Senator Packwood noted that, "While the nation's hospital industry may not agree with the Inspector General's findings, it has been reported that the industry's own data also indicates that hospital profit margins have grown."

The Chairman said the Subcommittee on Health expects to receive testimony from representatives of the hospital industry. "We will provide the industry with an opportunity to comment on its profit margin increases under Medicare and, more importantly, on whether and to what extent the relative financial health of the hospital industry can be maintained," Senator Packwood said.

He noted that under PPS a hospital is allowed to retain any savings it may realize by treating a patient for less than the Medicare payment rate. If the treatment exceeds the Medicare rate, however, the hospital must absorb the loss. The payment system was designed to encourage the nation's hospitals to be more efficient, Senator Packwood said.

Senator Packwood said Senator David Durenberger (R-Minnesota), Chairman of the Subcommittee on Health, would preside at the February 21 hearing.

REMARKS OF SENATOR DAVE DURENBERGER, HOSPITAL PROFITS UNDER MEDICARE PROSPECTIVE PAYMENT

Three years ago Congress created the prospective payment system, PPS, to promote more cost-effective management of hospital services for Medicare patients.

The system was a compact between Medicare and the hospital community: Hospitals agreed to cooperate in a radical new payment system, and the government agreed to give fair annual increases in rates. Hospitals which achieved savings through increased cost-efficiency, and which could provide services less than the PPS rate, could pocket the difference.

Since that time, the record shows that hospitals have been excellent partners in that compact. They have achieved a great deal. The length of hospital stay for Medicare patients is down an average of two days. Prospective payment has also made a difference for the Medicare payer, the hospital trust fund—in other words, the taxpayer. We established PPS as a "budget neutral" reform, and yet, since its inception the hospital community has *saved* the hospital trust fund $8 billion. That is no small achievement, especially in a government known for buying designer toilet seats.

Just two years ago the Medicare trust fund was facing bankruptcy. Today we are confident of entering the second millennium with a solvent Medicare program.

At the same time, the prospective payment system also includes safeguards to protect the quality of health care. And, in fact, there is no statistically definitive evidence that the quality of care has suffered under PPS.

I have heard claims to the contrary and seen the evidence. It looks and sounds very dramatic, and makes for good TV—but it is anecdotal at best. And, importantly, it ignores the dangerous abuses, such as unnecessary hospitalization and surgery, which existed before PPS and which the system was designed to correct.

In response to these achievements, what has the hospital industry heard from the federal government? Each year they have been asked to accept less than the prescribed increase in rates.

Some in Washington have attempted to justify that policy by identifying problems with data, the coding practices of hospitals, or whatever. For FY86, according to the administration and many of my congressional colleagues, this set of problems justified no increase in the PPS rate at all.

Now, the administration is proposing, at best, a two percent increase in the rate for FY87. That's less than half the increase prescribed by law, which is based on the market basket price plus one-quarter percent.

This scenario strikes me as a less than desirable way to make policy. Certainly a less than effective way to encourage continued improvements in health care financing and delivery, let alone to engender trust in federal policymakers. No doubt our hospitals are looking forward to the next terrific deal we have to offer them in the name of reform.

I have opposed, and continue to oppose, the use of reform—or even of deficit reduction—as a license to fiscally shortsheet the nation's hospitals. Especially for a program, Medicare, which over the past five years has contributed more than $38 billion in federal spending cuts.

Today we will hear from the Inspector General about survey data which imply that hospital profit margins under PPS are excessive. I suspect those data will fuel administration efforts to justify further reductions in PPS rates. There are those who dispute those profit figures, for various reasons.

But apart from the dispute over numbers, I don't remember any discussions during the development of PPS about capping rate increases because of hospital profit margins, excessive or otherwise. One wonders if our PPS rate policy is to be a mechanism for manipulating hospital budget under Medicare. I certainly never thought so.

The point of prospective payment is to give hospitals the opportunity to save money, or make money, through better management. Obviously, Americans have a huge stake in the financial health of their hospitals. A strong bottom line means we are securing the services and quality of our hospitals for the citizens, elderly and otherwise, who depend on them for care.

This morning we will examine the Inspector General's figures on hospital profits, and discuss their implications for hospitals and the Medicare patients they serve.

REMARKS OF SENATOR BOB PACKWOOD, HOSPITAL PROFITS UNDER MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

In October, 1983, Medicare introduced a radical new way of paying for hospital inpatient services. This system, known as prospective payment or PPS, provides hospitals with an incentive to be efficient—that is, to make choices on which services they provide to Medicare patients based on economic, as well as medical, considerations. If the hospital's costs are lower than the Medicare payment, the hospital can keep the difference as a profit.

All of the information we have to date indicates that hospitals have responded to the incentives in the new system even faster than we had hoped. The rate of growth in hospital costs has dramatically slowed and Medicare expenditures are lower. As Chairman of the Senate Finance Committee, this is good news. The 1987 deficit is lower now than it would have been had we not made this payment reform several years ago.

The reduction in hospital costs does not appear to have hurt the hospital industry. In fact, profit margins, which measure the amount of revenues that a hospital retains after all expenses such as medical staff salaries are paid, were at an all time high in 1984, the first year of the new system. In addition, there is no evidence that hospitals were realizing these profits by systematically failing to deliver the services for which they were being paid.

So the question is, did the hospital industry just go on a very successful cost reduction program, or were there other factors at work that contributed to the apparent financial success of the new system, such as the possibility that government set the payment rates too high? Can we expect the savings to Medicare and the profits to hospitals to continue at the same level, or will there be some changes over time?

We can't answer these questions because we don't have enough information. Data have not yet been analyzed, and in many cases the information we need was never collected. So the purpose of today's hearing is to establish a forum to look at the Medicare payment rates and the financial health of the hospital industry. Since Medicare pays approximately one-third of the hospital's patient revenues, these factors are very closely related.

We hope to learn more about this matter by the end of this hearing. Our witnesses today have the best answers to our questions. We look forward to their comments.

I. BACKGROUND

Effective for hospital cost reporting periods beginning on or after October 1, 1983, Medicare payment for inpatient hospital services is made according to a prospective payment system (PPS), rather than on a retrospective reasonable cost basis. Medicare payments are made at predetermined, fixed rates which represent the average cost, nationwide, of treating a Medicare patient according to his or her diagnosis. During a three-year transition period, a declining portion of Medicare's payments to a hospital are based on the hospital's historical reasonable costs. By FY 1987, Medicare's payments will be established on a nationwide basis with separate payment rates for hospitals in rural versus urban areas of the country.

The Medicare prospective payment system was developed to be "budget neutral" during the first two years. That is, any costs that were paid under the per case limit and rate of increase ceiling provisions of the Tax Equity and Fiscal Responsibility Act in FY 1983 were included in the PPS rates. Certain hospital costs, such as capital are excluded from the prospective payment system and continue to be paid for on a reasonable cost basis. In addition, certain hospitals, such as rehabilitation hospitals, are excluded from the system.

PPS introduced the concept of profit (defined as revenues less expenses) for the first time under Medicare as an incentive for hospitals to control costs. Prior to PPS, Medicare payments to hospitals were limited to reimbursement for reasonable costs. It was only for proprietary hospitals that return on equity was defined as a reasonable cost. Under PPS, if a hospital can treat a patient for less than the PPS payment amount, it can keep the savings. If the treatment costs more, the hospital must absorb the loss. A hospital is prohibited from charging Medicare beneficiaries any amounts which represent the difference between the hospital's cost of providing covered care and the Medicare payment amount, except for deductible and coinsurance amounts.

Because each hospital came under PPS at the beginning of its respective fiscal year, only 45 percent of all Medicare bills were paid under PPS during the first year, which ended September 30, 1984. |1| It was not until September, 1985 that all

PPS hospitals had completed 12 months under the new PPS system. Thus, due to the short period of time and lack of data, a complete assessment of PPS is premature. In addition, even as data become available, it will be difficult to isolate the PPS effect because other changes are occuring in the health care system, such as the growth of Health Maintenance Organizations (HMOs).

Since PPS was implemented, we do know that Medicare hospital utilization has fallen dramatically. In FY 1984, the length of stay for Medicare beneficiaries fell by 9 percent (or one full day) which was triple the 2.9 percent decline in FY 1983. Medicare admissions declined by 3.5 percent, the first decline since the program was initiated. |2| Coupled with significantly lower utilization by non-Medicare patients, hospital occupancy rates shrank from 74 percent in 1983 to 69 percent in 1984. |3| For-profit hospitals saw occupancy rates decline to as low as 52 percent by 1984. |4| Despite this lower utilization, the hospital industry reported record revenues and profits in 1984. For example, according to the American Hospital Association, profits on patient care for all U.S. community hospitals more than doubled during 1984. |5|

The amount and cause of these profits has implications for future levels of payment for Medicare and other payers.

II. INSPECTOR GENERAL REPORT

The Inspector General (IG) of the Department of Health and Human Services conducted a study of hospital profits attributed to the first year of the prospective payment system. |6| This study examined records at 892 hospitals (17 percent of all PPS hospitals) in 9 States. Profits were defined as Medicare revenues (PPS payments, adjustments for indirect teaching costs, outlier payments, and payments for return on equity) less PPS inpatient operating costs as reflected on unaudited 1984 Medicare cost reports. Medicare payments for depreciation, interest and direct medical education were excluded.

The study found net average profits ranging from a low of 1.65 percent for hospitals in Alaska to a high of 18.6 percent in Oregon. The net average profit margin for all hospitals in the study was were several times greater than the 3.3 percent after tax margins reported by Business Week for the services industry as a whole. The report also indicates that Medicare paid an excessive return on equity (24.17 percent average for the hospitals in the study vs. 13.9 percent for the services industry as a whole.) The report concludes that significant Medicare profits, averaging $934,000 per hospital, were made by most hospitals during their first year on PPS. Nineteen percent of the hospitals in the study experienced losses and these hospitals generally had a small volume of Medicare revenues. The IG report projects that Medicare may have paid up to $5 billion in profits systemwide. The report findings raise the question as to whether or not hospitals under PPS may have received excessive payments as a result of high PPS rates, inappropriate cost shifting, or other factors. Additional IG studies are underway to examine these issues, but have not been completed. The Health Care Financing Administration, the agency responsible for administering the PPS system, has not responded to the IG report.

III. INDUSTRY-WIDE PROFITS

All hospitals seek to earn a profit. Hospitals that are investor-owned (i.e. for-profit) return their profits to shareholders in the form of dividends or retain them. Hospitals that have tax exempt status under section 501(c) of the Internal Revenue Code, (i.e. not-for-profit) retain profits for future use.

There are two common ways of measuring and reporting profits -- net margins on patient care and net margins on total operations. Net margin is the percent of revenues that remain after expenses are deducted. Margins on patient care reflect revenues less expenses directly related to individual patients for inpatient and outpatient services, [e.g. they would not include revenues and expenses for a gift shop.] Margins on total operations reflect revenues less expenses for patient care plus all other revenues and expenses.

Table I summarizes profit margins reported by the American Hospital Association (AHA), Federation of American Hospitals (FAH), and Healthcare Financial Management Association (HFMA) in recent years. Table II summarizes revenue and expenses as reported by the AHA and FAH. It is important to understand several points about the data. First, each organization collects information from a different set of hospitals, using different survey questions. Thus, it is difficult to compare one data set to the other. The more relevant comparison is the trends over time. Second, the data are aggregate and include hospital outpatient costs as well as inpatient costs. Third, the data include non-PPS hospitals as well as PPS hospitals. And finally, the data do not separate out information by payer, such as Medicare. Such payer-specific data are not reported. Following are a few highlights from Tables I and II.

As shown in Table I, during the first year of PPS (1984), AHA reported that hospital profit margins on total operations increased from 5.1 percent to 6.2 percent. This was a jump of 22 percent over 1983, and more than double the increase of the five previous years added together. |7| Profit margins on patient operations increased at a higher rate than margins on total operations. AHA reported that patient margins doubled in 1984 over 1983, from 1.0 to 2.0 percent. |8| HFMA showed that patient margins increased 35 percent, from 2.3

percent to 3.1 percent. |9| Early AHA data for 1985 suggest that profit margins on total operations and patient operations are continuing to increase, however, at a lower rate than between 1983 and 1984. |10|

As shown in Table II, these profit margins translate into a large increase in dollars. According to AHA, from 1983 to 1984, net income on total revenues increased approximately 30 percent or $1.8 billion; while net income on patient revenues doubled from $1.2 billion to $2.5 billion. |11|

A recent study conducted by ICF, Inc., a private consulting firm, looked at the effect of changes in Medicare payment policies on hospital financial performance. This study constructed a Hospital Investment Simulation Model and predicted profit margins through 1990. The study showed that in 1984, all hospitals had level or lower profit margins on total operations relative to 1983. This finding is in contrast to data reported by AHA and HFMA. Data from ICF show that profit margins on patient operations will continue to decline through 1987 as a direct result of Medicare payment policies such as the freeze. However, ICF predicts that total margins will continue to be profitable for the industry as a whole. By 1990, the ICF model projects that all hospitals will have recovered and report profit margins higher than the 1983-85 level. It should be noted that this model is based on optomistic assumptions regarding utilization and growth of revenues, including Medicare revenues, after fiscal year 1986. |12|

The data in Tables I and II are aggregate and do not reflect the substantial variation in profit experience among hospitals. AHA reports that 73 percent of hospitals in their annual survey reported either higher or lower margins than the level reported in Table I. |13| In addition, AHA reports that the number of hospitals with negative margins are increasing. According to the panel survey, in 1983, 17 percent of hospitals reported negative total margins; by 1984, 22 percent reported losses. The number of hospitals with negative patient margins also increased, from 42 percent in 1983 to 45 percent in 1984. (The later annual survey shows the percent of hospitals with negative patient margins had increased to 52 percent). |14| On the other hand, many hospitals realized substantial profits. AHA reports that in 1984, 14 percent of hospitals had profits of 6 percent or more on patient revenues. |15| A Price Waterhouse survey of 293 hospitals found 67 percent of hospitals believed that they have done better under PPS than they would have under Medicare cost reimbursement. |16| Newspaper articles cite anecdotes of hospitals with windfall profits attributed to PPS, e.g. one hospital in Illinois realized a $9 million profit on total revenues of $147 million in 1984. |17|

There is also evidence of wide geographic variation in hospital profit margins. AHA reports that from 1983 to 1984, increases in total profit margins were reflected in all geographic regions, except the mountain and west south central regions. |18| In contrast, HFMA data show that northeast hospitals consistently report operating margins below other regions, while in the far west and southern regions the margins are especially large.|19| Both AHA and HFMA data show rural hospitals have lower profit margins than urban hospitals. HFMA data show rural hospitals with a 1.95 percent median compared to a 2.8 percent median for urban hospitals. However, in 1984 HFMA data show that rural hospitals significantly improved their profitability position, increasing 43.8

percent while urban hospitals increased 26.9 percent. |20|

Other characteristics appear to affect profitability. Both AHA and HFMA report that larger hospitals have higher profit margins than smaller hospitals. HFMA data show hospitals with 400 beds have an operating margin of 3.2 percent in 1984 compared to .9 percent for hospitals under 100 beds. |21| Teaching hospitals also reported higher profit margins in 1984 according to HFMA data. |22| Wall Street analysts conclude that not-for-profit hospitals have fared better than for-profit hospitals during the first two years of PPS due to their greater ability to cut costs; maintain higher occupancy rates; and lower capital costs. For-profit hospitals have been harder hit by the decline in occupancy rates. |23|

IV. REASONS FOR INCREASED PROFITS

Factors, other than the implementtion of the prospective payment system, must be considered in order to understand increased hospital revenues and profits. Most importantly, hospitals have reduced expenses. AHA estimates that the rate of growth in hospital expenses slowed from 10.2 percent to 4.6

percent between 1983 and 1984. [24] The largest area of reduction was staff costs. Beds have also been eliminated -- 1984 reflected a .6 percent decline, the first in 8 years. [25] Lower prices have also been negotiated with suppliers. The rate of growth in patient care costs slowed from 10.2 percent in 1983 to 7.5 percent in 1984 primarily due to a decline in the average length of stay. [26] In addition, inflation was moderate. The AHA market basket was 5.7 percent in 1983 and slowed to 5.3 percent in 1985. [27] AHA concludes that profits were up because the slowdown in expense growth was steeper than the slowdown in revenue growth. [28]

In addition to the slowdown in expenses, hospital revenues have increased because outpatient care expanded by 2 percent in 1984, and profitable new services, such as ambulatory surgery centers, were added. [29] Profit margins also appeared larger in 1984 because deductions from patient revenues, such as uncompensated care and bad debts, grew at a smaller rate, thus increasing net income. [30]

On the revenue side, there is some evidence that the Medicare payment rates may have been set artifically high. An audit by the General

Accounting Office (GAO) suggests that the 1981 base used to set PPS rates failed to deduct costs that should not have been allowed. These costs include some capital costs that should have been paid separately from PPS rates (e.g. capital costs allocated to ancillary departments) and hospital costs that would have been disallowed under an audit (e.g. patient care costs that were not reasonable and necessary). The GAO estimated that PPS payments were 4.3 percent too high, resulting in a $940 million excess payment for FY 1986. |31|

V. LONG TERM PROFITS

In spite of short term profits and the factors that contributed to them, the hospital industry is concerned about the ability of many hospitals to survive. Wall Street analysts concur with this assessment. One analyst predicts that hospital profit margins will essentially be stagnant for the rest of the decade, despite the growth of the elderly population. |32| Another analyst concludes that the profit margin of virtually every hospital will decline over the next 5 years. |33|

The primary concern regarding future profitability is the expectation that hospitals will have a difficult time increasing revenues. Excess bed capacity, resulting from decreased utilization and a shift to outpatient settings, will assure a "buyers market" for hospital care. The growth of HMOs and other prepaid plans will put additional pressure on hospitals to increase discounts. Also, Medicare payments may be limited by several actions. First, Medicare plans to eliminate or reduce several features incorporated into PPS to ease the transition from retrospective to prospective payment, such as movement from rates based on hospital-specific costs to rates based on national costs and reduction of the indirect teaching adjustment. Second, budget reduction proposals, such as Gramm-Rudman-Hollings, may further limit current payments or expected increases. Other budget savings proposals, such as Medicare's proposal to incorporate capital into the PPS rate, could further reduce the hospital's ability to earn a high return on equity. As other third party payors, such as commercial insurers, change their payment systems to control costs, hospitals may receive less revenue.

A second concern is that it will be difficult for hospitals to reduce expenses in the future as fast as occurred between 1983 and 1984 unless major changes are made in the size of the facility or definition of services offered. The situation will be exacerbated if admissions continue to drop and the less intensive cases are shifted to outpatient settings. AHA reported that per case costs increased from 7.7 percent to 9.2 percent between 1984-85. |34|

If hospitals are not able to sustain their revenue growth over time, it will be increasingly difficult to borrow money, service debt, replace equipment and supplies, and in sum, survive. Observers estimate that 20 percent, or 1,000 hospitals may fail during the next 2-10 years. |35|

VI. ISSUES

While complete information is lacking, the information generated to date suggests that aggregate hospital profit margins have increased at a higher rate since PPS was introduced. However, the direct contribution of PPS to the increase is unclear. There is evidence that in the aggregate, patient care revenues, such as Medicare, have contributed about 1 percent to increased profit margins between 1983-84, the first year of PPS. On one hand, there is evidence that PPS rates may have been set too high, despite budget neutrality. GAO estimates that PPS rates are overstated by 4.3 percent because certain capital costs and unallowable patient care costs were not deducted from the base. The IG report raises further concern about whether Medicare payment rates may be excessive. However, a number of methodological questions have been expressed about the IG study design which need to be clarified before the IG conclusions can be accepted. For example, hospitals in the IG study were not randomly selected, and it is not clear that appropriate Medicare costs were included in the analysis. On the other hand, there is no overwhelming evidence that hospital margins in the aggregate are excessive compared to other industries, and there is evidence that some hospitals may have difficulty maintaining their profits in the long term.

Since one intent of PPS was to control costs, and profits were permitted as an incentive for hospitals to change their behavior, it could be argued that reduced hospital expenses and lowered utilization are evidence of the system's success. These hospital profits, whether high or low, therefore, should not be of concern, at least in the short term. However, the wide variation in profitability among hospitals raises question about the appropriate and/or equitable distribution of profits.

For the long term, the profitability issue raises several other questions -- what happens to hospitals that have significantly reduced revenues and have no other source of compensation? Will they reduce care to the poor; reduce quality of care; discontinue unprofitable services; or go out-of-business? Hospitals are undertaking various strategies to assure their survival, such as advertising, moving towards comprehensive health delivery systems stressing outpatient services; consolidation; and diversification by adding new lines of business, such as insurance. Whether these strategies will assure access for Medicare patients to necessary care, especially in rural areas, needs to be carefully monitored.

(C0340)

Table I

HOSPITAL PROFIT MARGINS[1]

	1981	1982	1983	1984	1985	% Increase In Profits 1983-84
Total Operations						
AHA Panel Survey[2]	4.7	5.1	5.1	6.2	6.5	22%
AHA Annual Survey[3]	3.6	4.2	4.2	5.1		21%
Patient Operations						
AHA Panel Survey[2]	.2	.7	1.0	2.0	2.2	100%
AHA Annual Survey[3]	-3.9	-3.0	-2.6	-1.7		53%
FAH - Investor-Owned Hospitals[4]	4.4	5.1	4.2	4.8		14%
FAH - Management Company Hospitals[5]		6.4	5.9	5.9		-0-
HFMA[6]	2.0	2.0	2.3	3.1		35%

1) Aggregate data - reflects hospitals under the Prospective Payment System (PPS) and exempt hospitals. Includes inpatient and outpatient services.

2) Survey conducted by the American Hospital Association (AHA) representing a sample of hospitals to give early information on hospital trends. Data is for community hospitals for year ending December. For 1985, data reflects year ending October.

3) Annual survey reflecting 91 percent of all hospitals in the AHA files. Data reflects average margins for community hospitals.

4) Survey data collected by the Federal of American Hospitals' (FAH) annual survey. Reflects two-thirds of for-profit hospitals.

5) Reflects subset of FAH annual survey (84 percent) -- hospitals in multifacility management companies are defined as three or more hospitals commonly owned.

6) Survey of 1,400 subscriber hospitals conducted by the Healthcare Financial Management Association (HFMA). Data reflects mean margins.

(C0343)

Table II

HOSPITAL REVENUES
(in billions)

	1982	1983	1984	% Increase In Profits 1983-84
AHA Panel Survey				
Net total revenues	$115.0	$126.7	$134.3	
Expenses	109.1	120.2	126.0	
Net total income	5.9	6.5	8.3	28%
Net patient revenues	$109.9	121.4	128.5	
Expenses	109.1	120.2	126.0	
Net patient income	.8	1.2	2.5	108%
AHA Annual Survey				
Net total revenues	$109.5	121.4	129.9	
Expenses	104.9	116.4	123.3	
Net total income	4.6	5.0	6.6	32%
Net patient revenues	$101.8	113.5	121.3	
Expenses	104.9	116.4	123.3	
Net patient income	- 3.1	- 2.9	- 2.0	45%
FAH Annual Survey				
Net total revenues	N/A	10.6	12.6	
Expenses		10.0	11.8	
Net Income		.6	.8	33%

Data Sources for Tables I and II

AHA, National Panel Survey, Twenty-Year Data Set December 1963-1982

Data from AHA, Office of Public Policy Analysis, Chicago, Ill.

Hospital Statistics, 1985 Edition, AHA

Statistical Profile of the Investor-Owned Hospital Industry, 1984 FAH

Hospital Industry Analysis Report, 1980-1984, William O. Cleverly, Healthcare Financial Management Association.

Data from HFMA, Washington, D.C.

(C0344)

FOOTNOTES

1) Guterman S and Dobson A., "The Impact of the Medicare Prospective Payment System for Hospitals," Health Care Financing Administration, November, 1985.

2) *Ibid*.

3) American Hospital Association (AHA), *Hospital Statistics, 1985 Edition*, Chicago, Ill., 1985.

4) Federation of American Hospitals, phone conversation, 2/5/86

5) AHA, *Hospital Statistics, 1985 Edition*.

6) Kusserow, Richard P., Inspector General, "Priority Audit Memorandum -- Large Profits Earned by Hospitals Under the Medicare Prospective Payment System", (ACN: 09-62021) -- memorandum to C. McClain Haddow, Acting Administrator, Health Care Financing Administration, October 29, 1985.

7) AHA, Office of Public Policy Analysis, Economic Studies, Chicago, Ill., phone conversation 2/6/86.

8) American Hospital Association, *Economic Trends*, Autumn, 1985.

9) Cleverly, William O., "Hospital Industry Analysis Report 1980-1984", Healthcare Financial Management Association, 1985.

10) AHA, *Economic Trends* Autumn, 1985; AHA, "1985 Hospital Revenue Margins - Panel Survey Results", January 28, 1986.

11) AHA, *Hospital Statistics, 1985 Edition*.

12) The ICF Hospital Investment Simulation Model, ICF, Inc., Washington, D.C.

13) AHA, "Hospital Financial Margin Variation from the 1984 Annual Survey", January 31, 1986.

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33) Abramowitz, Kenneth, "The Future Health Care Delivery in America", Bernstein Research, July, 1985

34) AHA, "Hospital Costs and Utilization Through September, 1985".

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Senator DURENBERGER. The hearing will come to order.

Three years ago Congress created the prospective payment system to promote more cost-effective management of hospital services to Medicare patients, a compact between Medicare and the hospital community. Hospitals agreed to cooperate in a radical new payment system and the Government agreed to give fair annual increases in rates. Hospitals that achieved savings through increased cost efficiency, and could provide services less than the PPS rate, could pocket the difference.

Since that time, the record shows hospitals have been excellent partners in that compact. They have achieved a great deal. The length of hospital stay for Medicare patients is down an average of 2 days.

Prospective payment made a difference for the Medicare payer, the hospital trust fund, in other words, the taxpayer.

We established PPS as budget neutral reform, and yet, since its inception the hospital community has saved the hospital trust fund $8 billion. That is no small achievement, especially in a government known for buying designer toilet seats.

Just 2 years ago the Medicare trust fund was facing bankruptcy. Today we are confident of entering the second millennium with a solvent Medicare Program.

At the same time, the prospective payment system also provides safeguard protection to the quality of health care. In fact, there is no statistically definitive evidence that the quality of care has suffered under PPS.

I have heard claims to the contrary and have seen the evidence. And my colleague to my right probably has not. It looks and sounds very dramatic, and makes for good TV, but it is anecdotal at best. He will disagree with that also. And, importantly, it ignores the dangerous abuses, such as unnecessary hospitalization and surgery, which existed before PPS and which the system was designed to correct.

In response, what has the hospital industry heard from the Federal Government? Each year they have been asked to accept less than the prescribed increase in rates.

Some in Washington have attempted to justify that policy by identifying problems with data, the coding practices of hospitals, or whatever. We will explore that today.

For fiscal year 1986, according to the administration and many of my colleagues, this set of problems justified no increase in the PPS rate at all. Now the administration is proposing, at best, a 2 percent increase in the rate for fiscal year 1987. That is less than half the increase prescribed by law, which is based on the market basket price plus one-quarter percent.

The scenario strikes me as a less than desirable way to make policy and certainly a less than effective way to encourage continued improvements in health care financing and delivery, let alone to engender trust in Federal policymakers. No doubt our hospitals are looking forward to the next terrific deal we have to offer them in the name of reform.

I have opposed, and continue to oppose, the use of reform or even of deficit reduction as a license to fiscally shortsheet the Nation's hospitals. Did you get that? [Laughter.]

Shall I repeat it? Especially for a program, Medicare, which over the past 5 years has contributed more than $38 billion in Federal spending reductions.

Today we will hear from the inspector general about survey data which implies that hospital profit margins under PPS could be excessive. I suspect this data will fuel administration efforts to justify further reductions in PPS rates. There may be those who dispute those profit figures and for various reasons. And that we will hear today.

But apart from the dispute over numbers, I do not remember any discussions during the development of PPS about capping rate increases because of hospital profit margins, excessive or otherwise. One wonders if our PPS rate policy is to be a mechanism for manipulating hospital budget under Medicare. I hope not; I certainly never thought that it would be.

Americans have a huge stake in the financial health of their hospitals. A strong bottom line should mean that we are securing the services and the quality of care that our hospitals were designed to deliver for the citizens, elderly and otherwise, who depend on them for care.

On the quality issue, let me only conclude by saying that the relationship between this bottom line and the administration of the hospitals, and the investment in the hospitals has a lot to do with the ability of those hospitals to deliver the quality care that many are currently complaining of.

So this morning we will examine the inspector general's report, his figures on hospital profits, and discuss with representatives of the hospital industry and with a former Secretary of HHS the implications for hospitals and for Medicare patients that they serve.

John.

Senator HEINZ. Mr. Chairman, thank you.

First, let me commend you on holding this hearing. I think it is very important. Medicare is a program that affects the health and welfare of 30 million Americans. In many States, Medicare accounts for between 40 and 50 percent of all the revenues of hospitals. In my own State of Pennsylvania it is about 42 percent. Add in Medicaid and it is close to 55 percent. I must confess that I am disappointed. It is, I think, something of an embarrassment to the Senate that only two of the Members of the entire Senate are here. Certainly there are a few members of the Health Subcommittee that might be here, but a hearing like this is open to any Member of the Senate. And I think that when you are talking about health care delivery, roughly 40 to 50 percent of it, and how it is doing under our new Government rules, that it is a significant subject.

As you mentioned, Mr. Chairman, DRG's did substantially change the operating climate for hospitals. It is no longer enough for hospitals just to be care givers. Hospitals are now in the business of giving care. And I do have some concern, Mr. Chairman, about whether or not the patient is being given the business too.

As chairman of the Special Committee on Aging, my concern is a bit less on how much hospitals make and a bit more on what kind of care they provide to America's seniors on Medicare.

We do know—we are not naive—that there are incentives built into the DRG Program for hospitals to maximize profits, or minimize costs, if you prefer, per patient by minimizing the number of days of care. That in and of itself, as I have said on repeated occasions, is not bad. But there is a risk that some hospitals will put the bottom line first and actually endanger the lives and well-being of older patients. I must say that the testimony before the Committee on Aging, and studies by the General Accounting Office, the Office of Technology Assessment, the inspector general on several occasions—and Mr. Mitchell is here from that office—indicate that there are some problems with care under DRG's, including premature and inappropriate discharges, negligent or nonexistent discharge planning, pressures on doctors to discharge before they feel the patient is stabilized, and failure to inform patients of their right to appeal a discharge.

Mr. Chairman, you said my concerns were anecdotal at best.

We will have a chance to hear from the inspector general about their anecdotes, but I would ask the rhetorical question as to when a succession of verified anecdotes becomes a health policy problem?

I think the legitimate answer to that is when there is a recognized pattern among providers. And in their November 1985 report, the inspector general found repeated patterns of these so-called anecdotes involving specific providers and specific hospitals. They are waving a red flag at us, Mr. Chairman. And I suspect that we would be best off not to be like little carvings that people bring back from the Far East with the three monkies: one with their hands over their eyes, one with their hands over their ears, and, finally, less something untold happens, one over their mouths as well.

It is no secret that we had some fat built into the Medicare payment system for hospitals. DRG's are a valuable, important attempt to render that fat out of the program. We have already cut $30 billion out of Medicare overall, in total, over the last 6 years. We clearly need to monitor the system carefully to make sure we do not slice too closely to the core. I understand that the inspector general's office will testify today that payment rates still may be excessive, given actual costs of care; that 1984 was a record profit year for the 5,400 hospitals participating in the Medicare Program.

When Mike Bromberg, from the American Federation of Hospitals, and I were on NBC last week he said, "Hospitals were in the red for 1985," and that he was worried about quality if Congress continued to ratchet down on rates like the President has already decided to do for 1986. He has not had to wait for Congress to do that. A lot of the savings in the reconciliation bill that we had, where Congress was ratcheting down, have already been implemented by regulation.

I think we need to solve three things here today. First, what is the bottom line for hospitals in 1985? And what does it look like hospitals are going to see in 1986?

Second, if profits indeed are down, is the problem with Medicare reimbursement levels or is the problem related to overbuilding or some other business decision, or decisions that did not pan out?

And, finally, does all of this affect the quality of care given Medicare beneficiaries?

For the past 25 years our Nation has committed an ever-growing proportion of its GNP to health care, about 7.4 percent, as I recollect, back in 1975, around almost 12 percent today, a substantial increase. That commitment was fueled by the resolve that all citizens deserve the highest quality of care available.

I hope we do not decide to nickel and dime this commitment to death, even in this deficit-clouded climate.

Mr. Chairman, I know that you have many concerns about Medicare. We have spoken together and on the floor in support of trying to make sure we do retain a good Medicare system. I hope that this hearing today will allow us to move ahead and continue the commitment that I think, at bottom, we all share to quality of care under Medicare.

Senator DURENBERGER. Thank you very much. And, John, I could not agree more with the way you framed the three issues that I think face us here today in terms of at least our responsibility on this committee to the rest of the Senate, and to both the payers into the trust fund and the Medicare beneficiaries in this country. And I fully endorse that outline.

Max, do you have an opening statement?

Senator BAUCUS. No statement. Thank you, Mr. Chairman.

Senator DURENBERGER. All right. Let me introduce a couple of people that are here. Jean leMasurier, who is new to our staff, who did the research and the background for this hearing. And as many of you know, Bob Hoyer has gone to smaller and better things. And he has been replaced by the person who has been our talented legislative counsel, Bruce Kelly, on the ranking side of the subcommittee. And as many of you know, these are the real talents on this subcommittee. So I thought you should know that those two significant changes have taken place.

Our first panel, representing Dick Cusaro, because he is off some place, Europe. I don't know where it is. But Bryan Mitchell is here as Acting Deputy Inspector General, accompanied by Larry Simmons, the Deputy Assistant Inspector General for Audit, Department of Health and Human Services, Washington, DC. And we are really pleased to welcome back to the hearing table Nathan Stark, who was former Under Secretary of the Department of Health and Human Services; formerly of the University of Pittsburgh; a former Minnesotan. I don't know what he had, maybe 100 in Montana at one time. I am not sure. But from the old days when all of us were breaking in on this committee, Nathan, we welcome you back to give us your advice as well.

Let's begin with Bryan Mitchell.

Let me indicate to all of you that your full statements will be made part of the record, and that we have a 5-minute time limit for everybody here.

STATEMENT OF BRYAN B. MITCHELL, ACTING DEPUTY INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC., ACCOMPANIED BY LARRY SIMMONS, DEPUTY ASSISTANT INPSECTOR GENERAL FOR AUDIT

Mr. MITCHELL. Thank you, Mr. Chairman.

We welcome this opportunity to appear before you today to discuss our survey on hospital profits and losses under the Medicare's prospective payment system.

Under PPS, hospitals are reimbursed a fixed amount per Medicare discharge. If hospital costs exceed the fixed payment, the hospital incurs the loss. If costs are less than PPS payments, the hospital earns a profit.

Since implementation of PPS nearly 2½ years ago, there have been reports concerning the negative financial impact of this system on health care providers. At the same time, there were reports of recordsetting profit margins by hospitals in certain areas. However, sufficient data did not exist to permit evaluation of the actual situation.

To obtain information for the Health Care Financing Administration on the early financial impact of PPS, we began to survey Medicare cost reports of participating hospitals. Our survey was designed to compute Medicare profits or losses from Medicare inpatient services for a sample of hospitals during their first reporting period under PPS. We extracted and analyzed Medicare inpatient cost and revenue data from the initial PPS cost reports submitted by selected hospitals in nine States. Although unaudited, these cost reports were certified as being accurate by each provider.

Our review included all available 1984 Medicare cost reports in the nine States selected as part of our survey: Alaska, California, Connecticut, Florida, Illinois, Minnesota, Oregon, Taxas, and Washington.

Since about 40 percent of all PPS hospitals are located in these States, the cost reports that were available provided a representation of the average profit or loss from PPS during the first year of its implementation.

In the 9-State review, we collected and analzyed data from the Medicare cost reports of 892 hospitals of the 5,405 nationwide that were under PPS. The data we studied pertained only to Medicare PPS costs and revenues. In our analysis, we defined Medicare profit as the difference between a hospital's reported Medicare inpatient revenue and Medicare inpatient costs.

In determining Medicare inpatient revenue, we included return on equity, DRG revenue, outliers, and indirect medical education payments. In developing Medicare inpatient operating costs, Medicare pass through amounts, such as capital, direct medical education, and bad debts, were not included since these items are reimbursed independently of the PPS mechanism.

Inpatient revenue and cost amounts were extracted from the sections of the Medicare cost report. We made no attempt to determine profit or loss for non-Medicare hospital business or for the hospitals' total business operations.

The results of our initial survey were reported in an audit memorandum issued to the Health Care Financing Administration on October 29, 1985. And with your permission, Mr. Chairman, we will submit this for inclusion in the record.

Senator **Durenberger**. It will be made part of the record.

[The memorandum follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date OCT 29 1985

From Richard P. Kusserow
Inspector General

Subject Priority Audit Memorandum -- Large Profits Earned By Hospitals Under The Medicare Prospective Payment System (ACN: 09-62021)

To C. McClain Haddow
Acting Administrator
Health Care Financing Administration

We have been analyzing 1984 hospital cost reports submitted to fiscal intermediaries in order to determine profits generated in the first year of operation of the Medicare Prospective Payment System (PPS). We examined all available hospital records in nine States. This included 892 hospitals of the nationwide total of 5,405 that were under PPS.

The results of our analysis indicate hospitals earned a net average of in excess of 14 percent profit under Medicare PPS. Computing in the aggregate indicates that these profits would total as much as $5 billion.

In our survey, we defined Medicare profits to a hospital as the difference between DRG revenues (including outlier payments) received and Medicare's portion of inpatient operating costs as reported on the 1984 Medicare cost reports submitted to the fiscal intermediaries. We excluded from our calculation all Medicare pass through revenues and costs, except return on equity.

The data collected and tabulated on the 892 hospitals indicates that significant Medicare profits were made by most hospitals during the 1984 reporting period -- the first year of PPS reimbursements (see Exhibit A). For example:

- Hospitals earned a net average 14.12 percent profit under the Medicare prospective payment reimbursement system.
- Net profits for the 892 hospitals totalled over $833 million.
- The net average ratio of profits to equity equalled 24.17 percent.
- Overall, 81 percent of the hospitals realized profits. Those hospitals experiencing losses generally had a small volume of Medicare revenues.

The magnitude of the profits being earned by hospitals under PPS is exemplified by the following:

o A not-for-profit, tax exempt community hospital in California realized a $2,982,460 profit on Medicare revenue of $17,048,650, or a profit margin of 17.5 percent. This hospital's ratio of profits to equity was 29.6 percent.

o A proprietary, investor owned hospital in Texas earned $2,591,248 on Medicare revenues of $8,013,354 or 32.3 percent. The ratio of profits to equity for this facility was 59.3 percent.

As the above displays, we used two widely recognized measures of profitability as part of our study -- profit margin and ratio of profits to equity. Not-for-profit hospitals do not report how much of their equity relates to Medicare inpatient services. Therefore, we derived it by first calculating the hospital equity (assets minus liabilities) and then allocating a portion of the equity to Medicare inpatient services on the basis of revenues.

The profits earned by these hospitals through DRG payments are several times greater than those reported in a recent survey by companies in the Service Industry, of which hospitals are a part. According to Business Week, the Service Industry average profit margin was 3.3 percent in 1984 and the return on equity was 13.9 percent. We recognize that the PPS profit margin and the Service Industry margin are not exactly comparable. The PPS rate is before taxes while the Service Industry is after taxes. However, the difference between the two profit margins may not be significant because most of the PPS profits (about 83 percent) were earned by not-for-profit facilities which pay no income taxes.

The cost reports from which we extracted revenue and cost data were unaudited. Because fiscal intermediary audits of hospitals generally show that the expenditures on cost reports are inflated due to the inclusion of unallowable costs, our calculation of the net profits earned may be low. We examined all cost reports for the first year of PPS that were on hand at the fiscal intermediaries at the time of our visits. Although our selection of the 892 hospitals was not made on a statistically random basis, a nonstatistical projection of the average hospital profit we computed indicates that hospitals, in the aggregate, have earned billions of dollars in profits under the Medicare PPS system. These profits could total up to $5 billion (see Exhibit B).

We are continuing our review of the hospital profitability under PPS and plan to analyze the profits by hospital location, type and bed size. These preliminary findings raise questions as to whether hospitals under PPS may have been receiving excess payments. The data to date does not clearly attribute how much of these high profit levels are as a result of (1) setting the DRG reimbursement levels too high, (2) inappropriate cost shifting, and (3) some other factors. As we continue our analysis, we will identify the underlying causes of the large profits.

We welcome any comments you might have on our analysis and observations to date. If you would like to discuss our review, please let us know.

Mr. MITCHELL. The data collected and tabulated on the 892 hospitals indicate that Medicare profits were made by most of these hospitals during the 1984 reporting period. Our results, summarized in chart 1, shows that: Hospitals earned a net average 14 percent profit under Medicare Prospective Payment System; profit per hospital averaged $933,833; net profits for the 892 hospitals totaled over $833 million; the net average ratio of profits to equity totaled 24 percent; overall, 81 percent of the hospitals realized profits and 19 percent incurred losses. Those hospitals experiencing losses generally had a low volume of Medicare revenue.

We used two widely recognized measures of profitability as part of our survey: profit margin and ratio of profits to equity.

Not-for-profit hospitals do not report how much of their equity relates to Medicare inpatient services. Therefore, we derived it by first calculating the hospital equity—assets minus liabilities—and then allocating a portion of the equity to Medicare inpatient services on the basis of revenues.

Our chart 2 summarizes the net average Medicare profits that we computed for the hospitals in each State. And we will submit it for the record, Mr. Chairman.

[Chart 2 follows:]

EXHIBIT A

MEDICARE PROFITS EARNED BY HOSPITALS

STATE	NUMBER OF HOSPITALS REVIEWED	NET AVERAGE PROFIT MARGIN (Note 1)	NET AVERAGE RATIO OF PROFITS TO EQUITY (Note 1)
Texas	268	17.92%	26.13%
Minnesota	131	13.49	24.26
Florida	130	11.61	23.72
Illinois	119	12.82	19.86
California	95	13.89	28.58
Washington	83	13.69	21.88
Oregon	34	18.64	30.95
Connecticut	27	14.94	22.10
Alaska	5	1.65	1.97
TOTALS	892	14.12 (Note 2)	24.17 (Note 2)

Note 1: Medicare profits were calculated by subtracting PPS inpatient operating costs from Medicare revenues under PPS. The PPS revenues included payments for return on equity and excluded all other "pass-through" payments, such as depreciation, interest and direct medical education. The pass-through costs applicable to these were also excluded.

Note 2: The average profit margin of 14.12 percent and the average ratio of profits to equity of 24.17 percent are weighted averages for all 892 hospitals.

Mr. MITCHELL. The cost reports from which we extracted this revenue and cost data had not been audited by the fiscal intermediaries. However, the work done by us and GAO indicates that the unallowable costs generally averaged about 3 percent.

Since issuing our initial audit memorandum, we have arrayed our profit data on the 892 hospitals for comparison by hospital type. Chart 3, which we will submit for the record, shows this information.

[Chart 3 follows:]

EXHIBIT B

PROJECTION OF HOSPITAL PROFITS UNDER PPS

Total Number of Hospitals Reviewed	892
Total Profits Calculated (Including Return on Equity of $43,551,950)	$833,024,000
Average Hospital Profit	$ 933,833
Number of PPS Hospitals at 9/30/84	5,405
Total Projected Profits (Including Return on Equity of $264 Million)	$ 5.047 Billion

Mr. MITCHELL. We are continuing our review of hospital profits under PPS. We have expanded our initial sample of the 892 hospitals to nearly 50 percent of the hospitals participating under PPS. This was done in order to broaden the geographical distribution of hospitals. We have obtained additional cost reports and are in the process of summarizing and analyzing the data.

Preliminary indications from the expanded data sample indicate overall profit margins consistent with those discussed above from our initial survey.

This concludes our testimony, Mr. Chairman. We will be happy to answer questions.

Senator DURENBERGER. Thank you very much, Mr. Mitchell.

Mr. Stark.

[The prepared statement of Mr. Mitchell follows:]

TESTIMONY OF BRYAN B. MITCHELL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ON HOSPITAL PROFITS UNDER PPS

GOOD MORNING, MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, I AM BRYAN B. MITCHELL, ACTING DEPUTY INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. WITH ME TODAY IS LARRY K. SIMMONS, DEPUTY ASSISTANT INSPECTOR GENERAL FOR AUDIT. WE WELCOME THIS OPPORTUNITY TO APPEAR BEFORE YOU TODAY TO DISCUSS OUR SURVEY ON HOSPITAL PROFITS AND LOSSES UNDER MEDICARE'S PROSPECTIVE PAYMENT SYSTEM (PPS).

THE MEDICARE PROSPECTIVE PAYMENT SYSTEM (PPS) WAS AUTHORIZED BY THE SOCIAL SECURITY AMENDMENTS OF 1983. UNDER PPS, HOSPITALS ARE REIMBURSED A FIXED AMOUNT PER MEDICARE DISCHARGE. IF HOSPITAL COSTS EXCEED THE FIXED PAYMENT, THE HOSPITAL INCURS A LOSS. IF COSTS ARE LESS THAN THE PPS PAYMENT, THE HOSPITAL EARNS A PROFIT.

SINCE IMPLEMENTATION OF PPS NEARLY 2-1/2 YEARS AGO, THERE HAVE BEEN REPORTS CONCERNING THE NEGATIVE FINANCIAL IMPACT OF THIS SYSTEM ON HEALTH CARE PROVIDERS. AT THE SAME TIME, THERE WERE REPORTS OF RECORD SETTING PROFIT MARGINS BY HOSPITALS IN CERTAIN AREAS. HOWEVER, SUFFICIENT DATA DID NOT EXIST TO PERMIT EVALUATION OF THE ACTUAL SITUATION.

TO OBTAIN INFORMATION FOR THE HEALTH CARE FINANCING ADMINISTRATION ON THE EARLY FINANCIAL IMPACT OF PPS, WE BEGAN TO SURVEY MEDICARE COST REPORTS OF PARTICIPATING HOSPITALS. OUR SURVEY WAS DESIGNED TO COMPUTE MEDICARE PROFITS OR LOSSES FROM MEDICARE INPATIENT SERVICES FOR A SAMPLE OF HOSPITALS DURING

THEIR FIRST REPORTING PERIOD UNDER PPS. WE EXTRACTED AND ANALYZED MEDICARE INPATIENT COST AND REVENUE DATA FROM THE INITIAL PPS COST REPORTS SUBMITTED BY SELECTED HOSPITALS IN NINE STATES TO THEIR FISCAL INTERMEDIARIES. ALTHOUGH UNAUDITED, THESE COST REPORTS WERE CERTIFIED AS BEING ACCURATE BY EACH PROVIDER.

OUR REVIEW INCLUDED ALL AVAILABLE 1984 MEDICARE COST REPORTS IN THE NINE STATES SELECTED AS PART OF OUR SURVEY. THE NINE STATES INCLUDED ALASKA, CALIFORNIA, CONNECTICUT, FLORIDA, ILLINOIS, MINNESOTA, OREGON, TEXAS AND WASHINGTON. SINCE ABOUT 40 PERCENT OF ALL PPS HOSPITALS ARE LOCATED IN THESE STATES, THE COST REPORTS THAT WERE AVAILABLE PROVIDED A REPRESENTATION OF THE AVERAGE PROFIT OR LOSS FROM PPS DURING THE FIRST YEAR OF ITS IMPLEMENTATION.

IN THE NINE STATE REVIEW, WE COLLECTED AND ANALYZED DATA FROM THE MEDICARE COST REPORTS OF 892 HOSPITALS OF THE 5,405 NATIONWIDE THAT WERE UNDER PPS. THE DATA WE STUDIED PERTAINED ONLY TO MEDICARE PPS COSTS AND REVENUES. IN OUR ANALYSIS, WE DEFINED MEDICARE PROFIT AS THE DIFFERENCE BETWEEN A HOSPITAL'S REPORTED MEDICARE INPATIENT REVENUE AND MEDICARE INPATIENT COSTS. IN DETERMINING MEDICARE INPATIENT REVENUE, WE INCLUDED RETURN ON EQUITY, DRG REVENUE, OUTLIERS, AND INDIRECT MEDICAL EDUCATION (IME) PAYMENTS. IN DEVELOPING MEDICARE INPATIENT OPERATING COSTS, MEDICARE PASS THROUGH AMOUNTS SUCH AS CAPITAL, DIRECT MEDICAL EDUCATION AND BAD DEBTS WERE NOT INCLUDED SINCE THESE ITEMS ARE REIMBURSED INDEPENDENTLY OF THE PPS MECHANISM.

INPATIENT REVENUE AND COST AMOUNTS WERE EXTRACTED FROM THE SECTIONS OF THE MEDICARE COST REPORT (FORM HCFA-2552-84) RELATING TO PPS, TITLE XVIII, PART A, ON WORKSHEET E - CALCULATION OF REIMBURSEMENT SETTLEMENT. WE MADE NO ATTEMPT TO DETERMINE PROFIT OR LOSS FOR NON-MEDICARE HOSPITAL BUSINESS OR FOR THE HOSPITALS' TOTAL BUSINESS OPERATIONS.

THE RESULTS OF OUR INITIAL SURVEY WERE REPORTED IN AN AUDIT MEMORANDUM ISSUED TO THE HEALTH CARE FINANCING ADMINISTRATION ON OCTOBER 29, 1985. WITH YOUR PERMISSION, MR. CHAIRMAN, I WILL SUBMIT THIS AUDIT MEMORANDUM FOR INCLUSION IN THE RECORD.

THE DATA COLLECTED AND TABULATED ON THE 892 HOSPITALS INDICATES THAT MEDICARE PROFITS WERE MADE BY MOST OF THESE HOSPITALS DURING THE 1984 REPORTING PERIOD. OUR RESULTS, SUMMARIZED IN CHART 1, SHOW THAT:

- HOSPITALS EARNED A NET AVERAGE 14 PERCENT PROFIT UNDER THE MEDICARE PROSPECTIVE PAYMENT SYSTEM.
- PROFIT PER HOSPITAL AVERAGED $933,833.
- NET PROFITS FOR THE 892 HOSPITALS TOTALLED OVER $833 MILLION.
- THE NET AVERAGE RATIO OF PROFITS TO EQUITY TOTALLED 24 PERCENT.

- OVERALL, 81 PERCENT (719) OF THE HOSPITALS REALIZED PROFITS AND 19 PERCENT (173) INCURRED LOSSES. THOSE HOSPITALS EXPERIENCING LOSSES GENERALLY HAD A LOW VOLUME OF MEDICARE REVENUE.

WE USED TWO WIDELY RECOGNIZED MEASURES OF PROFITABILITY AS PART OF OUR SURVEY - PROFIT MARGIN AND RATIO OF PROFITS TO EQUITY. NOT-FOR-PROFIT HOSPITALS DO NOT REPORT HOW MUCH OF THEIR EQUITY RELATES TO MEDICARE INPATIENT SERVICES. THEREFORE, WE DERIVED IT BY FIRST CALCULATING THE HOSPITAL EQUITY (ASSETS MINUS LIABILITIES) AND THEN ALLOCATING A PORTION OF THE EQUITY TO MEDICARE INPATIENT SERVICES ON THE BASIS OF REVENUES.

CHART 2 SUMMARIZES THE NET AVERAGE MEDICARE PROFITS WE COMPUTED FOR THE HOSPITALS IN EACH STATE. THESE PROFIT RATES, BY STATE ARE AS FOLLOWS:

- TEXAS - 17 PERCENT
- MINNESOTA - 13 PERCENT
- FLORIDA - 11 PERCENT
- ILLINOIS - 12 PERCENT
- CALIFORNIA - 13 PERCENT
- WASHINGTON - 13 PERCENT

- OREGON - 18 PERCENT
- CONNECTICUT - 14 PERCENT
- ALASKA - 1 PERCENT

AS INDICATED, OREGON HOSPITALS HAD THE HIGHEST RATE AT 18 PERCENT AND EXCLUDING ALASKA, WHERE DATA FROM ONLY 5 HOSPITALS WERE INCLUDED IN OUR SURVEY, FLORIDA HOSPITALS HAD THE LOWEST RATE OF 11 PERCENT.

THE COST REPORTS FROM WHICH WE EXTRACTED REVENUE AND COST DATA HAD NOT BEEN AUDITED BY THE FISCAL INTERMEDIARIES. AUDITS OF HOSPITALS GENERALLY SHOW THAT REPORTED HOSPITAL COSTS ARE INFLATED DUE TO THE INCLUSION OF UNALLOWABLE COSTS, THEREFORE, OUR CALCULATION OF MEDICARE PROFIT RATES MAY BE LOW. AUDIT OF 1981 PPS BASE YEAR HOSPITAL COSTS BY THE GENERAL ACCOUNTING OFFICE DISCLOSED THAT UNALLOWABLE COSTS AVERAGED ABOUT THREE PERCENT OF REPORTED EXPENSES.

SINCE ISSUING OUR INITIAL AUDIT MEMORANDUM, WE HAVE ARRAYED OUR PROFIT DATA ON THE 892 HOSPITALS FOR COMPARISON BY HOSPITAL TYPE. AS SHOWN IN CHART 3, WE COMPARED COMPUTED PROFIT RATES FOR THE PROPRIETARY AND NON-PROFIT HOSPITALS IN OUR SAMPLE. FOR THE 144 PROPRIETARY HOSPITALS SURVEYED, NET PROFITS AVERAGED

ABOUT 17 PERCENT INCLUDING RETURN ON EQUITY PAYMENTS AND ABOUT 12 PERCENT EXCLUDING RETURN ON EQUITY. IN COMPARISON, THE NONPROFIT HOSPITALS SURVEYED AVERAGED MEDICARE PROFITS OF ABOUT 13 PERCENT.

CHART 4 COMPARES THE COMPUTED PROFITS FOR TEACHING AND NON-TEACHING HOSPITALS IN OUR SURVEY. FOR THE 104 TEACHING HOSPITALS, PROFITS AVERAGED 17 PERCENT INCLUDING IME PAYMENTS AND 14 PERCENT EXCLUDING IME. THE 788 NON-TEACHING HOSPITALS AVERAGED PROFITS OF ABOUT 12 PERCENT.

CHART 5 COMPARES COMPUTED PROFIT RATES BETWEEN URBAN AND RURAL HOSPITALS IN OUR SURVEY. NET PROFITS COMPUTED FOR THE 501 URBAN HOSPITALS AVERAGED 15 PERCENT. FOR THE 391 RURAL HOSPITALS, THE NET PROFIT RATE AVERAGED ABOUT 7 PERCENT.

WE ARE CONTINUING OUR REVIEW OF HOSPITAL PROFITS UNDER PPS. WE HAVE EXPANDED OUR INITIAL SAMPLE OF 892 HOSPITAL REPORTS TO NEARLY 50 PERCENT OF THE HOSPITALS PARTICIPATING UNDER PPS. THIS WAS DONE IN ORDER TO BROADEN THE GEOGRAPHICAL DISTRIBUTION OF HOSPITALS. WE HAVE OBTAINED THE ADDITIONAL COST REPORTS AND ARE IN THE PROCESS OF SUMMARIZING AND ANALYZING THE DATA. PRELIMINARY INDICATIONS FROM THE EXPANDED DATA SAMPLE INDICATE OVERALL PROFIT MARGINS CONSISTENT WITH THOSE DISCUSSED ABOVE FROM OUR INITIAL SURVEY.

THIS CONCLUDES MY TESTIMONY, MR. CHAIRMAN. WE WILL BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

CHART 1

HIGHLIGHTS

TOTAL HOSPITALS REVIEWED	892
TOTAL NET PROFITS FOR 892	$833 MILLION
AVERAGE PROFIT PER HOSPITAL	$933,833
NET AVERAGE PROFIT MARGIN	14.2 PERCENT
NET RETURN ON EQUITY	24.1 PERCENT
WINNERS (719 HOSPITALS)	81 PERCENT
LOSERS (173 HOSPITALS)	19 PERCENT

CHART 2

MEDICARE PROFITS EARNED BY HOSPITALS

STATE	NUMBER OF HOSPITALS REVIEWED	NET AVERAGE PROFIT MARGIN	NET AVERAGE RATIO OF PROFITS TO EQUITY
Texas	268	17.92%	26.13%
Minnesota	131	13.49	24.26
Florida	130	11.61	23.72
Illinois	119	12.82	19.86
California	95	13.89	28.58
Washington	83	13.69	21.88
Oregon	34	18.64	30.95
Connecticut	27	14.94	22.10
Alaska	5	1.65	1.97
TOTALS	892	14.12	24.17

CHART 3

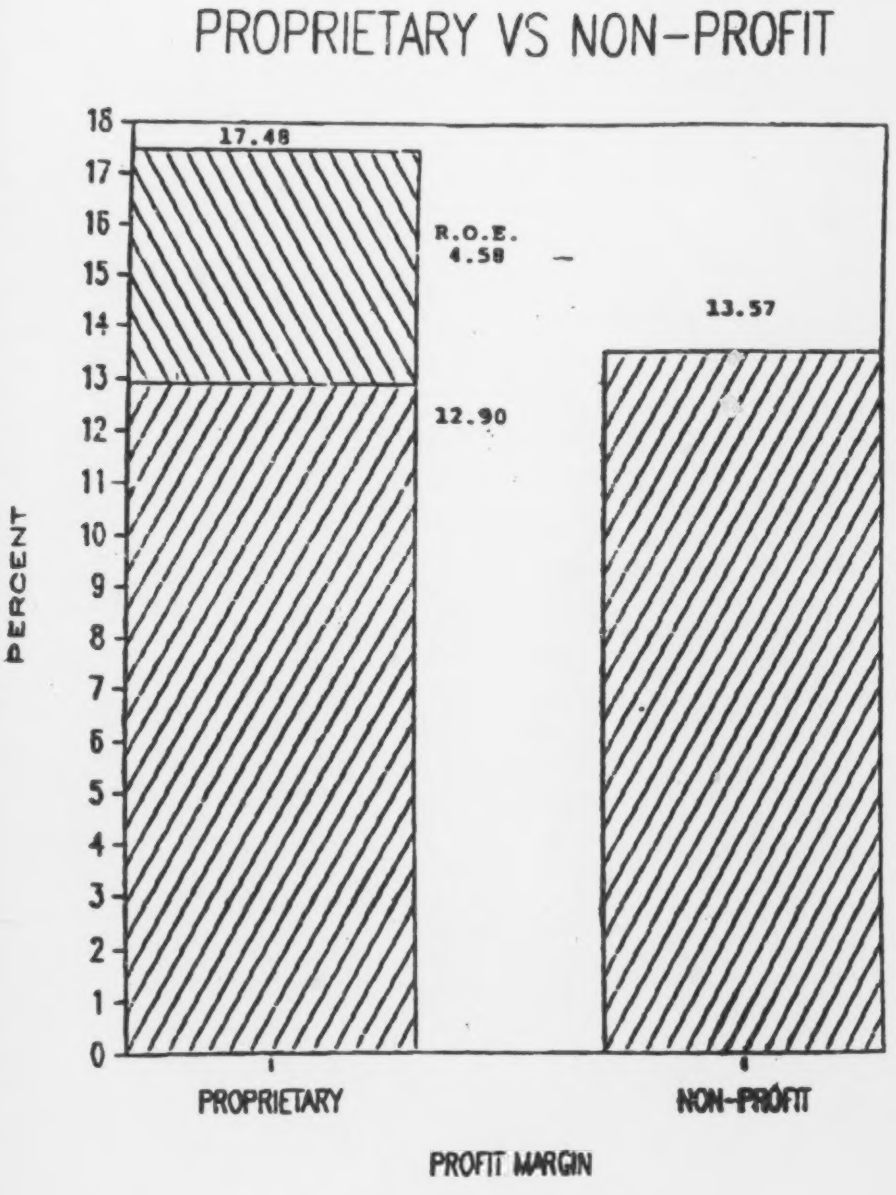

PROPRIETARY VS NON-PROFIT
PERCENT
0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
17.48
R.O.E.
4.58
12.90
13.57
PROPRIETARY
NON-PROFIT
PROFIT MARGIN

CHART 4

TEACHING VS NON-TEACHING

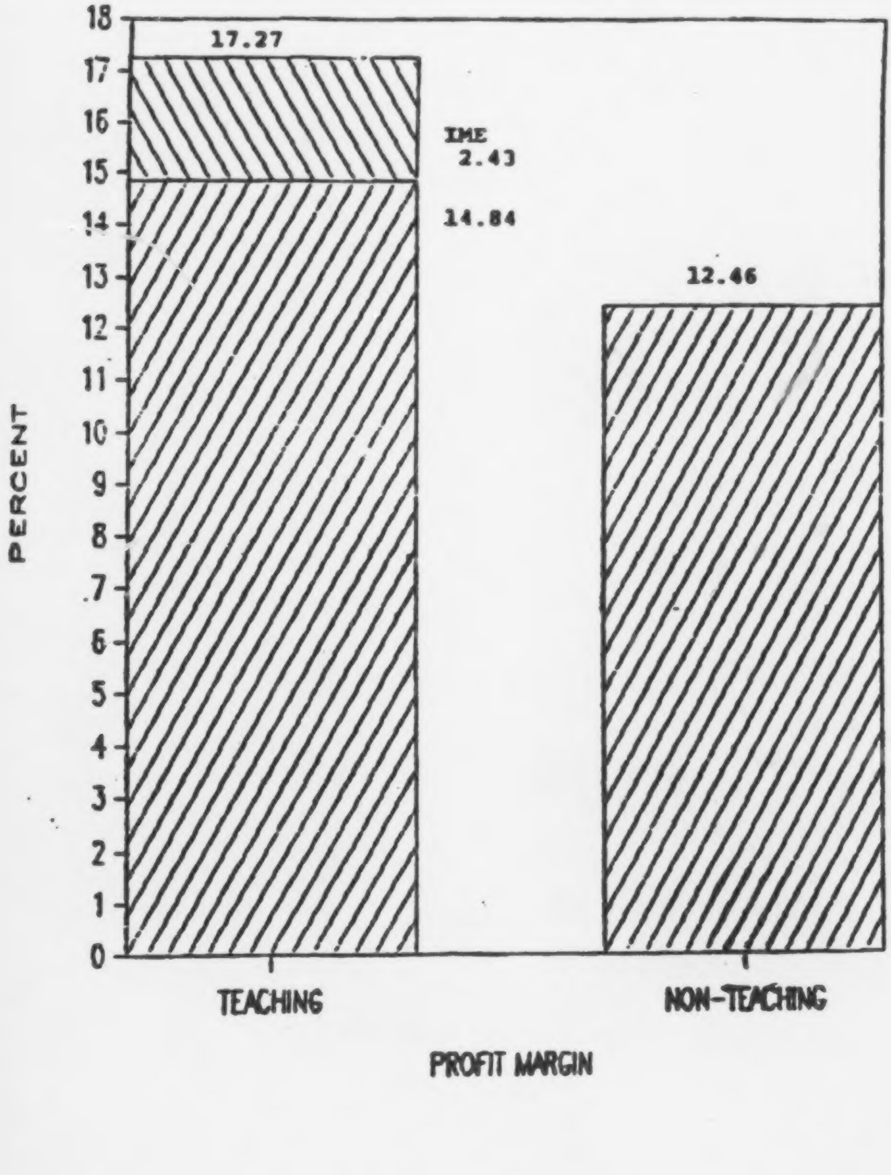
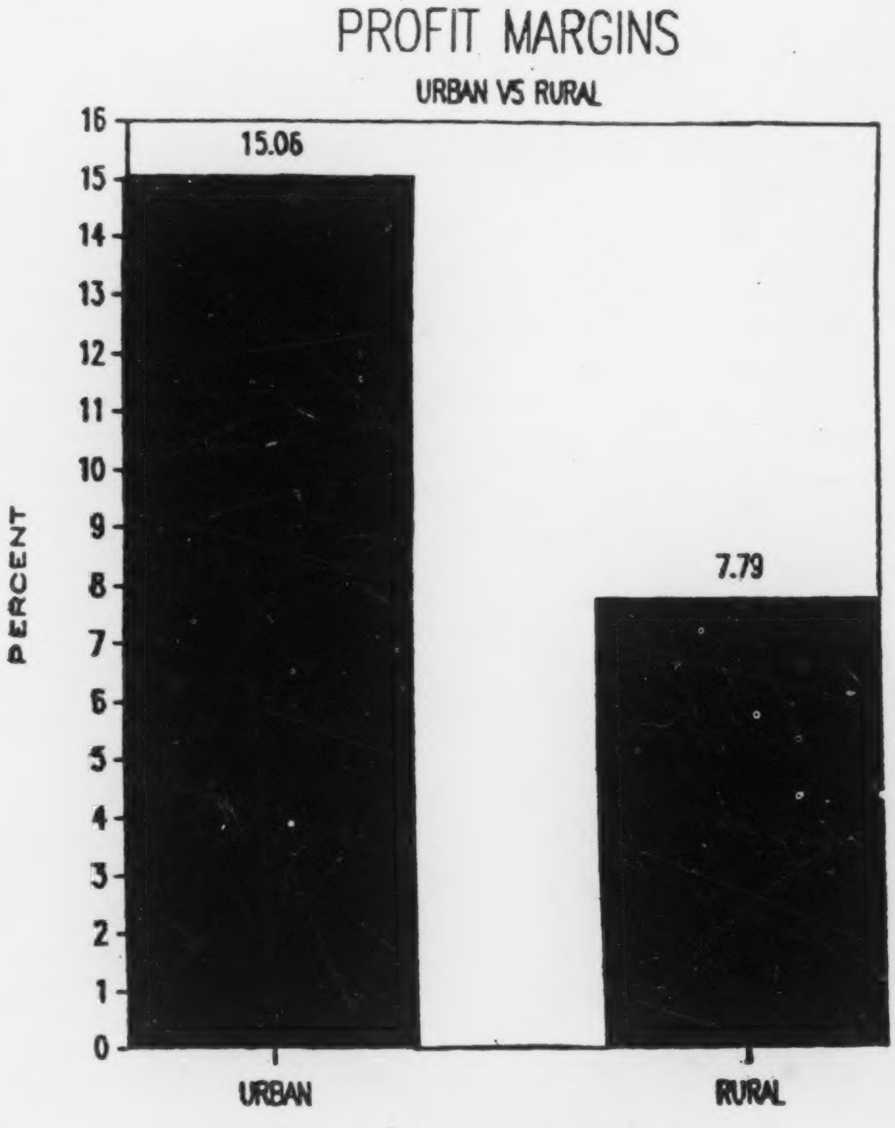


CHART 5


PROFIT MARGINS
URBAN VS RURAL
PERCENT
0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
15.06
7.79
URBAN
RURAL
URBAN OR RURAL HOSPITAL

STATEMENT OF NATHAN J. STARK, ESQ., FORMER UNDER SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. STARK. Thank you, Mr. Chairman.

I am very pleased to participate in this hearing. I suppose I ought to be cited as a public member at this time since I am not appearing as a representative of hospitals or the health care system. I am back here practicing law as an attorney, and as Senator Heinz noted earlier, I am back in the private sector. But I am very pleased to participate in this hearing with such distinguished representatives as the inspector general's office with whom I have worked in the past, and also with the American Hospital Association and the Federation of American Health Systems.

On the subject of this hearing, I stand on their side at least. As a member of the former administration charged with the responsibility of moving the hospital cost containment bill, our relations were then not quite so cordial.

I hope that the report that we have just listened to—and was reported recently by the inspector general—about hospital profitability under the prospective payment system would not cause Government policymakers to lose sight of the purpose of the PPS which was designed, at least in part, to compel efficiencies in our health care delivery system by encouraging hospitals to cut costs which, in turn, would save dollars for the Government, enhance the solvency of the Medicare Trust Fund, and at the same time maintain the hospital's financial viability.

Prior to 1984, hospitals were paid basically at their cost of service, including the number of days the Medicare patient spent in the hospital. Because the payment to the hospital was fixed in 1984 under PPS, hospitals were given a direct financial incentive to reduce their own cost, thereby injecting the incentive to be efficient. The more the hospital was able to lower its cost of treating Medicare patients, the greater the financial reward, and, of course, the quid pro quo for Government was reduced medical expenditures.

The response was dramatic. Reductions in staff and inventories reduced length of patients' stays, increased outpatient treatment, and the elimination of unnecessary testing.

Now these changes were implemented more quickly than anticipated. And the initial cost-cutting response to PPS is not likely to be capable of repetition in future years.

Whether or not some hospitals have made high profits or surplus under the program, the Government should not reward the achieved efficiency by freezing or slashing funding for health care.

The PPS Program has achieved the very results anticipated when the program was adopted. To now penalize hospitals with funding cuts because they have implemented the sort of cost-containment measures contemplated by PPS would be a mistake. I must comment here on another matter discussed in committee hearings and just recently in this hearing and in the news media, namely that some hospitals have sacrificed the quality of medical care in order to cut costs and increase their profit margins.

So far, this seems unjustified. Despite isolated reports of inadequate treatment, there is no empirical evidence that the Medicare public has suffered poorer care under the new system—and I say this advisedly—than under the old.

On the other hand, there is ample evidence that efficiency motivated health care delivery systems do not necessarily sacrifice the patient to the pursuit of profits.

I refer here to the experience—which you are very well aware of, Mr. Durenberger—and that is to the experience of HMO's. Just as hospitals are now motivated to keep their costs lower than the fixed amount PPS allows, HMO's have long been motivated to keep their costs lower than the predetermined enrollment fee they receive from their enrollees for virtually all services needed. Not only has enrollment increased dramatically over the past decade—and I'd say that this is an indication of consumer satisfaction with quality service—but all studies and surveys have shown that the quality of care provided by HMO's is equal to or better than that provided in the HMO's own community.

I have two reasons for urging that Government not react to reports of high medical profits by freezing or further reducing hospital payments. First, when the PPS Program was adopted, there was considerable concern in the industry because the PPS placed hospitals at financial risk if they did not implement effective cost-cutting measures. Failure to meet the challenge of managing costs could have put a large amount of the industry in the red. It seems contrary to fundamental notions of fair dealing for the Government, after adopting a program which put hospitals in a position of possible financial loss, to reward the efficiencies mandated by the program by penalizing hospitals with further budget cuts. This is particularly true because many of the cost savings implemented, as I said before, were one-time measures which cannot be repeated from year to year without reducing quality of services to Medicare beneficiaries.

Second, if it becomes clear to hospitals that the Medicare Program is going to be funded on the basis of the Government's perception of what profit is appropriate for them, over the long run hospitals will conclude that lowering costs or implementing more efficiencies in health care delivery will simply result in reducing their income. In effect, the Government will be imposing the same sort of rate regulation on hospitals that it has recently abandoned in other industries because it frustrated efficiency and innovation. When initiative and efficiency in health care are not rewarded to any greater extent than inefficiency, efforts at further cost containment will cease, and the Government's health care bill will again rise at an increasing rate.

Thank you.

[The prepared statement of Mr. Stark follows:]

STATEMENT OF NATHAN J. STARK ON HOSPITAL PROFITS UNDER THE MEDICARE PROSPECTIVE PAYMENT SYSTEM

My name is Nathan J. Stark. I am a partner in the Washington, D.C. law firm of Kominers, Fort, Schlefer & Boyer. I served as the Under Secretary of the Department of Health and Human Services between 1979 and 1980. Following government service and prior to entering the practice of law, I was Senior Vice Chancellor of the University of Pittsburgh's six health science schools and President of the University Health Center of Pittsburgh, made up of six university teaching hospitals.

In the recent controversy over hospital profitability under the Prospective Payment System (PPS), Government policy makers should not lose sight of the fact that the PPS program was designed in part to compel efficiencies in the nation's health care delivery system and to encourage hospitals to cut costs in order to make money. Regardless of whether some hospitals have made high profits or surplus under the program, the Government should not reward the efficiency generated by the program by freezing or slashing funding for health care. The PPS program has achieved the very results anticipated by the Government when it adopted the program, and it would be a mistake to penalize hospitals with funding cuts because they have implemented the sort of cost containment measures required by PPS.

In 1984 when Medicare payment to hospitals was changed to a fixed rate under the PPS program, hospitals were given a direct financial incentive to reduce their own costs. The program injected the incentive to be efficient into the health care system -- the more a hospital was able to lower its cost of treating Medicare patients, the greater its profits. The Government expected to benefit from this efficiency by reduced Medicare expenditures.

While I will leave it to others to provide the details, there is no doubt that in response to the PPS program hospitals implemented reductions in staffs and inventories; they reduced the length of patient stays, increased outpatient treatment, and eliminated unnecessary testing. Employment in the industry decreased, and the annual rate of employee salary increases dropped. These changes were implemented more quickly than anticipated, and the depth of the initial cost-cutting response to PPS is not likely to be capable of repetition in the future.

As a result of the steps implemented by hospitals, the Government experienced the lowest historical rate of annual increase in Medicare expenditures, and the solvency of the Medicare Trust Fund was enhanced, thereby prolonging the life of a social program at one time thought to be on the verge of bankruptcy.

The suggestion that the efficiency-oriented Medicare program has reduced the quality of patient care seems unjustified. Despite isolated reports of inadequate treatment, there is no empirical evidence that the Medicare public has suffered poorer care under the new system than under the old, and there is ample evidence that efficiency-motivated health care delivery systems do not necessarily sacrifice the patient to the pursuit of profits. The evidence to which I refer is the experience of health maintenance organizations. Just as hospitals are now motivated to keep their costs lower than the fixed amount they will receive from Medicare under PPS for providing a given service, HMOs have long been motivated to keep their costs lower than the predetermined enrollment fee they have received from their enrollees for virtually all services needed. Not only has enrollment in HMOs increased dramatically over the past decade, indicating consumer satisfaction with the quality of service, but all studies and surveys have shown that the quality of care provided by HMOs is equal to or better than that provided by others.

I earlier indicated that it would be a mistake for the Government to react to reports of high Medicare profits by freezing or reducing hospital payments. There are two reasons. First, when the program was adopted there was considerable concern in the industry because the PPS would place hospitals at financial risk if they did not implement effective cost-cutting measures. Failure to meet the challenge of managing costs could have put a large segment of the industry in the red. It seems contrary to fundamental notions of fair dealing for the Government, after adopting a program which put hospitals in a position of possible financial loss, to reward the efficiencies mandated by the program by penalizing hospitals with further budget cuts. This is particularly true because many of the cost-savings implemented were one-time measures which cannot be repeated from year to year.

Second, if it becomes clear to hospitals that the Medicare program is going to be funded on the basis of the Government's perception of what profit is appropriate for them, over the long run hospitals will conclude that lowering costs or implementing more efficiencies in health care delivery will simply result in reducing their incomes. In effect the Government will be imposing the same sort of rate regulation on hospitals that it has recently abandoned in other industries because it frustrated efficiency and innovation. When initiative and efficiency in health care are not rewarded to any greater extent than inefficiency, efforts at further cost containment will cease and the government's health care bill will again rise at an increasing rate.

Senator DURENBERGER. Thank you very much. Mr. Mitchell, I want to direct my first question to the issue of return on equity. You excluded capital and direct medical education payments, as that is not part of the PPS mechanism, but you did include return on equity. You calculated a return on equity for nonprofit hospitals, and I don't know the degree to which you may have done comparisons of return on equity rate for the particular hospital before and after PPS, but could you just explain the importance of the return on equity issue in this study—and can you give us any comparisons on the issue of return on equity before and after the installation of PPS?

Mr. SIMMONS. Senator Durenberger, let me make an attempt to answer your question. First of all, we included return on equity capital in the revenue side of our formula because, in our view, return on equity capital which is paid to hospitals is a profit item. It sort of—HCFA defines it as an element of cost, but from an auditor's standpoint it's really not an element of cost. It's an additional payment which we consider a profit; that's why we put it in the revenue side.

We computed, secondly, two measures of profit. We computed rates of return as far as profit as a percentage of revenue, and we also made an attempt to compute a second measure, which is a commonly used measure, and that is a return on investment. And so in doing that we computed net equity for a hospital related to Medicare inpatient services and related the profit to that. So, I guess the short answer is we considered the return on equity amount, which is only paid to proprietary hospitals under Medicare, an element of profit, and therefore we put it in the revenue side.

Senator DURENBERGER. Did you make any before and after comparisons—were you able to do that on——

Mr. SIMMONS. We didn't do any 1983 versus 1984 comparisons, but we did sort of on chart 3—if you want to turn to it—it's in the back of the testimony—we did a proprietary versus nonprofit comparison where it quantified the effect of return on equity capital. Including return on equity capital in our computations there is about a 4 to 5 percent spread; it adds about 4 to 5 percent to the profit margins of proprietaries.

Senator DURENBERGER. OK. Are you now broadening the study; is new study getting started to cover at least 50 percent of the hospitals?

Mr. SIMMONS. Yes, sir; we are. As you know, the 892 was not statistically drawn——

Senator HEINZ. Could you say that again?

Mr. SIMMONS. The 892 hospitals that we studied were not statistically drawn. The reason they were not statistically drawn is that providers don't all file their cost reports at the same time. In response to newspaper articles and other kinds of information about profit levels being made, we wanted to get—as fast as we could—get our hands on whatever cost reports were out there, so we went to 9 States that have intermediaries that have large numbers of Medicare cost reports, and we got the early ones that were filed, and we got 892 in 9 States. We admit it was not statistical. It was a large number, but it's not statistically drawn.

Senator DURENBERGER. I asked you the return on equity question for a couple of reasons, but one of them has to do with the issue of capital reimbursement, which we have to enter into. In the process of moving to a 50 percent sample, are we too late—John and I and Max and anybody that might have concern about not just this report but the information you can deliver—are we too late to interface with the base on which you are going to do the next phase of this study, in case we get any great ideas about how to improve what you are doing?

Mr. SIMMONS. Well, we have obtained the information from over 2,000 cost reports, and it has been tabulated in some form. We are analyzing the raw data now, and, as we said in the statement, Senator Durenberger, we have reconfirmed actually that the profit level went up a little bit. It is still in the 14 point range, but it actually increased. The problem with our sample is that we did not have a large number of hospitals that have fiscal years starting July 1. They tend to be hospitals that are teaching hospitals, that have—they are large in size and they have large Medicare revenues.

Senator DURENBERGER. That's why I want to end on that particular issue, because we are going to hear from the District of Columbia and the issue of disproportionate share and teaching in the core city hospital. To what extent are you satisfied that in this first study you found enough information that you can help us deal better with the extra burden of certain hospitals because of location and size and so forth, or should we not expect too much from that part of it? Should we be looking to the next study to help us with that issue?

Mr. SIMMONS. I don't think the second study, the 2,000 plus sample, will really get at the issue of disproportionate share. I don't know what a disproportionate share hospital is and I know there are differences of——

Senator DURENBERGER. We are trying to define a——

Mr. SIMMONS. Yes, sir. I understand.

Senator DURENBERGER. You have got the general idea. That is all we have, too, I think. So——

Mr. SIMMONS. One of the things we have done separately is obtain some information on disproportionate share hospitals. I don't have it with me now, but we have some information. The National Association of Public Hospitals testified and identified 31 hospitals that they define as disproportionate share. They had a high proportion of local and State money, and they had high Medicaid populations. We have obtained information on those hospitals in addition to this data we are talking about in our 892 and our 2,000 cost report samples. We have gone out to 23 of the hospitals that they identified as being disproportionate share that are in the nonwaiver States. The other six or seven were in waiver States, so we didn't include them.

We went out and got cost reports for 23—I believe it was 23—that are in the nonwaiver States, to take a look at what those cost reports showed, and only one of those 23 hospitals had a loss. Only one hospital. The others made profits, and I think the average profit was about the 14 to 17 percent level that we are talking about here.

Senator DURENBERGER. All right. Thank you. John.

Senator HEINZ. Mr. Chairman, thank you. I am glad Mr. Simmons and Mr. Mitchell have dealt with the issue of the sample and I guess the witnesses from the various associations on the next panel will be critical of your methodology. You have done a good job of explaining that, and I think that disposes of that.

So, I have a question really for Nate Stark, former Pittsburgher, former Minnesotan, present and former Washingtonian. Nate, I guess I am sympathetic to any argument that it's a mistake to penalize hospitals with funding cuts because they have implemented the cost-containment strategies and efficiencies motivated by PPS, but as I understand what you are saying, you are saying that quality hasn't been affected, is that right?

Mr. STARK. No, I would say comparatively I don't think we have empirical evidence to show that it is any worse now than it might have been in the past. And I think when this issue of premature discharge is considered, Senator—I think we have to give recognition to the fact that the central question is not whether the patients are being discharged sooner, but rather whether the decision that a patient no longer requires acute inpatient hospital care is appropriate. I can go back many, many years now to the time before Medicare came into being, when hospitals were in a depression mode, and physicians thought hospitals owed them an extra living because at a time when hospitals needed money, they kept patients in hospitals longer than necessary.

We went from that situation to one where we felt that, while this was bad and we were trying to move patients out more quickly—and I don't think that was the purpose, by the way, of PPS; it may have been an indirect result of PPS, but it certainly wasn't the purpose—that one of the reasons for keeping patients in hospitals a longer time was that we had nowhere else to send them——

Senator HEINZ. Sure.

Mr. STARK. And I think what we need to look for is an insurance that we have an adequate amount of quality post-acute care facilities and staff, as well as providing adequate coverage for individuals for such service, and I think that is what you are aiming at on your Committee on Aging.

Senator HEINZ. One thing that we have heard from the hospital industry is—and this was Mike Bromberg's position a couple weeks ago—that there aren't any problems. On the other hand, the Hospital Association is saying, "But, there will be problems if we are ratcheted down."

Now, my general view is that those statements can be true, but the latter suggests the former is, in part, already true. There is a distribution of ability, management competence, efficiency, the fairness of the game that hits some hospitals one way. Some hospitals are going to be DRG winners; other hospitals are going to be DRG losers. As a result, when the Hospital Association says, "If you ratchet down these payments anymore, there are going to be wide-spread quality problems," that tells me there already are some quality problems as a result of this. Is that flawed reasoning on my part?

Mr. STARK. No, I do not think so. I think there are problems now. I think there have been problems in the past. And there is a possibility I think that if you squeeze down far enough, eventually that you are going to have to affect the beneficiary adversely.

Senator HEINZ. My time is about to expire, but there is a question that I hope Senator Durenberger will be here for because it is one—and I am not quite sure who I best pose it to, but I will start on it—it is this. We had a witness before the Aging Committee at our last hearing who was an extraordinary woman; her name is Eleanor Chelimsky. She works for the General Accounting Office, and I think the gentlemen from the IG are familiar with her. She is one of those truly extraordinary public servants who is highly competent and understands the ramifications of public policy. She said that the kind of information decisionmakers such as the Department of Health and Human Services or the Health Subcommittee or the Congress need—the kind of information decisionmakers have to have to make decent policy decisions—is not available. Her testimony, which I commend to every single person who gives the least damn about health care, is that we are not collecting the information that we absolutely, positively have to have to make policy judgments. And what made me think of that was your comment that we don't have a nominative base when it comes to quality to judge whether there is a deterioration in quality. You said that a minute ago.

We are not gathering the information that we ought to have to figure out, whether PPS is worse or better than the previous system. Even with all kinds of warning flags flying, we are still either reluctant or pleased with our ignorance about not wanting to know what we are doing. And that, it seems to me, is the cardinal sin. We are saying health policy be damned, full speed on cost cutting ahead. Is that right?

Mr. **Stark**. I couldn't agree with you more, Senator. I think Secretary Bowen has come up with one idea in trying to get a better handle on whether these premature discharges are actually causing problems for the beneficiary, and his idea is to have the present system, peer review, look carefully at every discharged patient who returns to the hospital within a certain period of time. I think he suggests 15 days.

Senator **Heinz**. What I am going to do—and I am glad my chairman has returned because, A, I have been speaking too long, and, B, I have an invitation I wish to propose to him—I intend to write a letter on which I hope he will join me, which will be based on the suggestions of Eleanor Chelimsky with some specificity on the kinds of information that we really should be gathering in order to make health policy decisions. I will draft a letter. It will go to Secretary Bowen, for whom I have great respect and high hopes. I think he inherits an extremely difficult situation. The purpose of the letter will be to ask him, giving him specifics, to try and implement an information-gathering system so that 2 or 3 years from now we are not going to go through the same kind of frustration, which is as frustrating for Dave Durenberger as it is for me, where we are saying, "Well, all that stuff was anecdotal," and 3 years from now we are saying, "It is still anecdotal," and why is that? Because we are not gathering the information to nail it down. Until we have an information system, it will always be anecdotal, and that is the problem.

Senator **Durenberger**. I will help you write the letter. How is that?

Senator **Heinz**. I will welcome all the help I can get on this one. But the real question is what can we do to make sure that the DHHS is in fact capable of getting that information, and that is going to be the hard part. The letter is the easy part.

Senator **Durenberger**. The research question.

Senator **Heinz**. Yes. Thank you, Mr. Chairman.

Senator **Durenberger**. John, thank you very much. Max.

Senator **Baucus**. Gentlemen, to address this question, obviously one problem that comes to mind is the degree to which the quality of health care has suffered, if it has at all, because of decreased profit margins of hospitals and as hospitals attempt to cut costs, certainly unnecessary costs. What should the standard be for measuring the quality of health care? What standard does HHS look at?

Mr. **Mitchell**. I don't know that I have an answer to that.

Senator **Baucus**. Perhaps, Mr. Stark, could you give us some ideas of what the proper standard should be, or whatever standards HHS uses for hospital use, to determine whether or not the quality of health care is increasing, decreasing, or about the same?

Mr. **Stark**. I think—I don't know whether they have any standards at HHS. I know that they are very reluctant to state what the standard might be, and heavily rely on peer review. And I suppose that when the reports that they get back after discharge papers are looked at, morbidity and mortality figures, they will accept the word of those in peer review who are perhaps best in position to judge quality. I would think that there would be consultation with the Assistant Secretary for Health, the Surgeon General, to establish standards.

Senator BAUCUS. I asked the question because we, as Senators and certainly members of this subcommittee, have to make some judgment as to whether health care is suffering or is not suffering, and to do that we have to know what the standards are. And I am wondering if you could suggest to us what standards should we apply in determining whether the quality of health care is suffering or not.

Mr. STARK. Well, the usual standards looked at are mortality and morbidity rates. Where you go from there, peer review is about the only suggestion that I can make. I think Senator Heinz' suggestion is a good one that some means be applied by Secretary Bowen to collect the necessary data which will give you a better view of what has happened in the past, what is happening now, and what the future portends. I can't give you any better answer than that. The profession itself is in a quandary as to what standards to apply.

Senator BAUCUS. Don't you think it is a critical question?

Mr. STARK. I think it is a very critical question, and it has been.

Senator BAUCUS. And one that should be, perhaps, focused on a little more.

Mr. STARK. It should be addressed now and in the future.

Mr. SIMMONS. Senator, clearly the mechanism in the Department is the peer review organization structure and the Health Care Financing Administration, of course, they administer that, but——

Senator BAUCUS. I understand that it is the peer review organization, but that is a little loose for us, and we don't know what is happening in the peer review. I don't know that we should, but we still don't.

Could you also explain, too, either Mr. Mitchell or Mr. Stark, if there is a disparity in profit margins between urban hospitals and rural hospitals, and, if so, to what degree?

Mr. STARK. Did you address that to me?

Senator BAUCUS. Either one of you.

Mr. STARK. Well, I won't try to answer, but I might suggest that the next panel would be better qualified to answer that on behalf of the hospitals at least. Perhaps the inspector general can give you some ideas.

Mr. SIMMONS. Senator Baucus, in our statement—we have a chart, chart 5, that indicates profit levels based on a comparison between urban and rural in our 892 that we did, and the profit levels for urbans were 15 percent and the profit levels for rurals were about half of that, 7.79. So that our data is indicating that the urbans are making almost twice as much profit as the rurals.

Senator BAUCUS. What explains why the rurals are suffering? I have figures which show that many rural hospitals are suffering losses.

Mr. SIMMONS. We have some information on that, too. Of the 391 rural hospitals of our 892, about one-third of those 300 plus hospitals had losses; the other two-thirds had profits.

Senator **Baucus**. Why is that? Why such a preponderance of lower profit margin, in fact, losses for so many rural hospitals? What explains that?

Mr. **Simmons**. We don't really have the total answer to that, although let me make an attempt to explain possibly some reasons. The rural hospitals tend to be small hospitals. Comparatively, what we are talking about here is maybe 80 beds or less. In our sample for a typical rural versus maybe a 185-bed hospital for an urban. So they are smaller to start with. OK.

We have talked to certain rural hospital operators—this is all anecdotal information. We haven't—basically, we are trying to understand why that is going on ourselves. But the rural hospitals are telling us that, No. 1, because they are small, they can't cost shift to the extent of the larger hospitals. They can't because they are locked into a population out there. They have low occupancy rates. Typically, the occupancy rates, I think, based on the AHA published data, shows that smaller hospitals have 40- and 50-percent occupancy rates versus 60- and 70-percent higher rates for the urban hospitals. So they have occupancy rate problems.

They also claim—we haven't validated this—but they claim that they are negatively impacted by the wage index in the program because they tell us that they tend to hire their personnel from urban centers where the wage index is higher, so they have to pay the higher wages. Yet in their PPS formula they are in a lower rated census area, so they get a lower payment there. So, it is a combination of things. I don't have the answer as to why. We are trying to understand that ourselves.

Senator **Baucus**. Do you have any tentative recommendations what changes, if any, PPS system should utilize in addressing the disproportionate profit margins between the rural and urban hospitals?

Mr. **Simmons**. No.

Senator **Baucus**. Any tentative recommendations at all?

Mr. **Simmons**. No. No; we don't, and some of these problems may correct themselves. For example, we went to rural hospitals in Texas. Rural hospitals in Texas, I think their average costs, average operating cost, tends to be less than the national average. Down there, although they may be losing money, they are saying as the transition to a national rate increases as we go to 50 to 75 and to 100 percent of the national rate, their profit picture is going to increase.

So, it is a complicated question. It depends on what their relative costs are versus the national average. If they are lower than the national average, as we blend into the national average rate, they will make money. We have this wage adjustment that has been proposed—I think it will be put in effect prospectively—which also may help them. So, there are some things already on the scene that may help correct the problem.

Senator **Baucus**. Well, frankly, one problem I have is the tyranny of averages. You know, the PPS system is based on averages, and theoretically to encourage inefficient hospitals to become more efficient and to reward those that are efficient. I understand that; that is the basic premise of the system. The problem is that some hospitals are caught in conditions through no fault of their own——

Mr. SIMMONS. I understand.

Senator BAUCUS. Conditions they cannot control, which, because of the average premise of the system, catches them.

Mr. SIMMONS. That is correct.

Senator BAUCUS. And we have made some adjustments already. For example, large urban hospitals have the teaching component, an additional little incentive, and it seems to me that the system should also address the rural problem, because many rural hospitals are caught through conditions not caused by them, through no fault of their own.

Frankly, Mr. Chairman, I think it would make sense if we had a hearing on that subject alone, that is the problems of rural hospitals and the degree to which PPS system should be modified in order to accommodate the problems of rural hospitals. It is clear that rural hospitals are suffering dramatically. As part of its economics with the farm crisis, rural communities are suffering. Insurance is the first to go; people just don't keep up their health insurance policies as their income drops.

Mr. SIMMONS. Our data does suggest, Senator, though, that two-thirds of the rural hospitals in our sample did make money. They were not losers. About one-third were losers. So, it is not automatic that if you are a rural hospital, you are going to lose money.

Senator BAUCUS. That is why——

Mr. SIMMONS. It depends on the circumstances that you were just explaining.

Senator BAUCUS. That is why I phrased it the way I did, that is the degree to which PPS system should be modified. I agree, it is not clear. But there is a very definite trend in the system, because it is based on averages and because rural hospitals have problems through no fault of their own—some through their own fault, but many caused by conditions that is not caused by them—that it is a problem that should be addressed.

Senator DURENBERGER. Let me just acknowledge our responsibility to do that, Max. As I listen to you explore this issue, part of it is definitional as his response indicates, but I have no doubt in my mind, and I am sure you don't, coming from the State you are coming from, that this is a split country. I mean, it used to be black and white; today it is urban and rural. And we are in effect deregulating this society in substantial ways, and it isn't just telephones we are deregulating. This is a good example right here in the health provider system, and that impacts very different. And we talk about disproportionate shares and inner-city hospitals as though that is the place where all the pain is. Bologna!

I mean, there is a lot more pain that comes with deregulating the financing of the delivery of services—a lot more pain is going to come in remote areas where there are fewer people per square mile, per square block, to finance the delivery of services than in these core cities. In the core cities, it is a problem of lack of political will to face up to these problems. And it is a combat between age groups and things like that that create some problems within these communities.

When you get out into the rural areas, it is a whole different set of problems that people can't do a lot about unless a national government displays some sensitivity to it. So, I think the work they have done here and your suggestion earlier, both of you, about the peer review organization, what they can tell us, if HCFA will take some of the financial handcuffs off of them, about what is going on out there in terms of the way people choose health service, is very important. Maybe we ought to be taking this around the country a couple of times, in different parts of the country, rather than right here in Washington, because those folks out there can't afford to come to Washington anymore to talk to us about those rural problems.

Senator BAUCUS. I think we need to have a separate hearing only on rural problems.

Senator DURENBERGER. Any other—any other questions?

Senator BAUCUS. We haven't talked about this, but do you agree to have a hearing?

Senator DURENBERGER. Well, I would love to, just talk to the chairman and get a time. All right?

Senator BAUCUS. Thank you.

Senator DURENBERGER. Gentlemen, thank you all very much. We appreciate you being here.

Now we have another panel—four people. Sam Howard, president-elect of Federation of American Health Systems, who has to leave early for Nashville; Jack Owen, executive vice president of American Hospital Association; Steve Lipson, president, District of Columbia Hospital Association; Ron Kovener, vice president of Healthcare Financial Management Association.

Gentlemen, your entire statements will be made part of the record of this hearing, and under the 5-minute time limit—why is that green light on already? OK. Under the 5-minute time limit, we will start with Sam, and I know you will stick to it.

STATEMENT OF SAMUEL H. HOWARD, PRESIDENT-ELECT, FEDERATION OF AMERICAN HEALTH SYSTEMS, AND SENIOR VICE PRESIDENT, PUBLIC AFFAIRS, HOSPITAL CORP. OF AMERICA, NASHVILLE, TN

Mr. HOWARD. Thank you. I am Samuel Howard, senior vice president of Hospital Corp. of America, president-elect of the Federation of American Health Systems. I was also honored to serve on the 1982 Advisory Council on Social Security, which addressed the Medicare Program.

We welcome this opportunity to present our views on hospital performance under the Medicare Prospective Payment System and the important issue of maintaining the financial health of the hospital industry. The Federation of American Health Systems strongly supported and actively worked for the passage of the Prospective Payment System. As a matter of fact, we considered it a contract. On April 20, 1983, we made this contract with Congress and the administration.

We agreed to manage our costs better, and you would allow us for the first time to keep the difference between what Medicare paid and our cost of providing care. We agreed to receive a predetermined amount for each Medicare patient based on his diagnosis, and you agreed to increase that amount annually by the amount of inflation in the hospital costs plus 1 percent. You agreed and we concurred to defer the decision on capital until 1986, when you, the Congress, would enact legislation to deal with capital-related issues under the Prospective Payment System.

Well, the first year, gentlemen, we know there was dramatic cost cutting by hospitals and savings to the Medicare Program. As a matter of fact, if you look at the projected expenditures for 1984, we saved Medicare Part A 6 percent, or $2.2 billion. How did we do this?

We did it by reductions in the growth in the full-time equivalent employees in the hospitals—the first reductions since World War II. We did it by shorter lengths of stay. There were also fewer inpatient admissions. But this particular reduction in labor costs, which represents 60 percent of the hospital expenditures, is a one-time phenomena.

Once you achieve an efficient level of staffing and wages, labor components are going to remain relatively static. Thus we cannot continue to produce the great savings achieved during the earlier phases of the Prospective Payment System.

But let me comment now on the contract. The administration seems to be continually changing the rules of the game. On April 20, we agreed to an increase in the DRG payments of the market basket plus 1 percent. Last year the Congress reduced this amount to the market basket plus a quarter, and now for 1986 we are talking about a freeze, no increase in the hospital payment.

These reductions in payments come at a time when the number of Medicare beneficiaries is growing. Over the next 10 years, we expect 18 percent more Medicare beneficiaries. We expect 51 percent more people over the ages of 85. This method of Government policy for paying hospitals will be damaging to the hospital profitability during the next 2 years.

We had a study conducted by ICF. It showed that the 1985 operating results of 5,354 hospitals was a loss of $1.7 billion. That number will increase to $3.4 billion in 1986 and $2.7 billion in 1987.

More importantly, 59 percent of these hospitals are going to fail to earn operating revenues in excess of expenses in 1986. Interesting data came out of that report—that you are going to be paying less for inpatient hospital admissions in 1987 than you did in 1984.

But it should be noted that this study is based on the optimistic projections that we will get a rate of increase in the DRG payments of the hospital market basket costs plus one-quarter of 1 percent. If payments are frozen, it is going to be much less. I shudder to think if we had frozen hospital payments for the last 10 years what improvements would not have happened in our system. How many intensive care units would not exist? How many cardiac units would not exist? What about the cat scanner? What about the MRI? What about the quantity and quality of care that we have come to expect in this country?

I think we would probably be a static or deteriorating health care system. Access to care is going to be similarly adversely impacted if you continue to freeze the prices.

Gentlemen, we understand the prospective payment law to be a contract. We have kept our part of the contract. The system is working. However, if the administration and Congress changes this contract by freezing or reducing hospital payments, then the hospital industry can hardly be expected to continue to endorse the program.

Reducing hospital payments to shrink hospital profits will force hospitals to reduce their intensity and their quality of services to Medicare beneficiaries. Breaking faith with the hospitals after we have responded precisely as anticipated and desired under the prospective payment system is a sure way to undermine our future support, particularly for any capital purposes and proposals.

We urge you to treat hospitals fairly and increase payment rates equitably. Thank you.

Senator DURENBERGER. Thank you very much, Sam.

Jack Owen.

[The prepared statement of Mr. Howard follows:]

PREPARED STATEMENT OF SAMUEL H. HOWARD, PRESIDENT-ELECT, FEDERATION OF AMERICAN HEALTH SYSTEMS

Summary

The Federation of American Health Systems strongly supported and actively worked for passage of a prospective payment system for Medicare hospital payments.

Hospitals have responsed to the new incentives of the prospective payment system by saving the Medicare program billions of taxpayer dollars through the implementation of sound management procedures designed to provide high quality care at a reasonable price.

The first year of the new prospective payment system yielded dramatic cost cutting by hospitals and savings to the Medicare program. The reductions experienced by hospitals in length of stay and the growth of full time equivalent employees during the initial phase of the prospective payment system produced a one time, temporary expansion in hospital operating margins.

However the current federal government's policy for reimbursing hospitals under the Medicare program will "have a substantially depressive effect" on hospital profitability during the next two years, according to a study by ICF, Incorporated. ICF projects that 59% of the hospitals covered by the prospective payment system will fail to earn operating revenues in excess of expenses in 1986.

Reducing hospital payments to shrink hospital "profits" will not reward hospital managers who have cut their costs by working with their staffs, physicians and patients to adapt to the new payment system. Breaking faith with hospitals after they have responded precisely as anticipated and desired under prospective payment is a sure way to undermine our support. We urge Congress to treat hospitals fairly, and increase payment rates equitably to assure the continuation of a system with the correct incentives and access to high quality health care for Medicare beneficiaries.

The Federation of American Health Systems, formerly the Federation of American Hospitals, is the national association of investor-owned hospitals and health care systems representing over 1,300 hospitals with over 164,000 beds. Our member management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent approximately 25 percent of all non-governmental hospitals. In many communities, investor-owned facilities represent the only hospital serving the population. I am Samuel H. Howard, President-Elect of the Federation of American Health Systems and Senior Vice President, Public Affairs for Hospital Corporation of America. I also served as a member of the 1982 Advisory Council on Social Security which addressed the Medicare program and the then projected $300 million deficit in the Medicare Trust Fund.

We welcome this opportunity to present our views on hospital performance under the Medicare Prospective Payment System (PPS) and the important issue of maintaining the financial health of the hospital industry.

Medicare Prospective Payment System

The Federation of American Health Systems strongly supported and actively worked for passage of a prospective payment system for Medicare hospital payments. The hospital industry on April 20, 1983 made a contract with Congress and the Administration.

We agreed to cut our costs and you would allow us for the first time to keep the difference between what Medicare paid and our cost of providing care.

We agreed to receive a predetermined amount for each Medicare patient admitted based on that person's diagnosis. You agreed to increase that payment rate annually by the amount of inflation in hospital input costs plus one percent. You also decided to defer the decision on capital until 1986, and that Congress would enact legislation to deal with capital related issues under the prospective payment system.

Hospitals have responded to the new incentives of the prospective payment system. We have saved the Medicare program billions of taxpayer dollars through the implementation or enhancement of existing sound management procedures designed to provide high quality care at a reasonable price. Due to the more careful management of admissions, labor costs and utilization of facilities, the hospital industry has succeeded in bringing hospital costs down dramatically.

Inspector General's Report

We strongly question the statistical validity of the Department of Health and Human Services Inspector General's report. The sample includes only 892 of the nations 5,405 hospitals covered by the prospective payment system and is not geographically nor institutionally representative. The prospective payment plan enacted by the government gradually moves hospitals toward an average national rate; therefore, hospitals in regions of the country that have maintained lower costs would experience larger margins than those hospitals with historically higher costs. Return on equity payments to investor owned hospitals are a capital pass through item and should have been treated as such for purposes of the Inspector General's analysis. These payments are not "profits" under the PPS system.

Hospital Profitability

The first year of the new prospective payment system yielded dramatic cost cutting by hospitals and savings to the Medicare program. Medicare Part A expenditures for 1984 were 6 percent or $2.2 billion less than projected. Reductions in the growth of hospitals' full time equivalent (FTE) employees, the first reduction since World War II, shorter lengths of stay and fewer inpatient admissions resulted in sizeable savings to the Medicare program and improved operating margins for hospitals. However, such reductions in labor costs, the largest budget item for hospitals (60%), are a one time phenomenon. Once hospitals achieve efficient levels of staffing and wages, labor components will remain relatively static and cannot produce the great savings achieved during the early phases of the prospective payment system. Hospital employment prior to PPS had been growing 3 to 4% per year and wages about 8 to 10% annually. The old cost based reimbursement system which essentially paid whatever costs a hospital incurred gave no incentives for limiting FTE growth or wage increases.

However, given a direct incentive to efficiently manage their staffing, hospitals responded immediately so that employment rates in the hospital industry are now decreasing and wage increases have dropped to about 5%, a rate more in line with other industries. The result of this and other cost containment measures during the early phase of PPS produced a one time, temporary expansion in hospital operating margins.

In 1985, the annual rate of increase in hospital expenditures through October was 6.1%. Considerably lower than the 15% rate of increase reported in 1982. Clearly, the Medicare hospital prospective payment plan is working. Hospitals have responded to the new incentives by cutting their expenditures.

Medicare Trust Fund Solvency

Furthermore, because Medicare outlays have dropped so significantly, the solvency of the Medicare Trust Fund has been assured through the rest of this century. As recently as 1984 it was predicted the Part A fund would be bankrupt in 1988. Hospitals have demonstrated that with the appropriate incentives they will vigorously cut costs. However, the right incentives under this system include an equitable rate of increase in payments from year to year, which as a minimum must be sufficient to cover the increased operating expenses caused by inflation of the hospital market basket and new technology. If hospitals feel their only reward for reducing hospital expenditures is to receive a freeze or reduction in future payments, there remains little reason for their continued support of the program.

Medicare Payment Policies and Hospital Margins

The Medicare Prospective Payment System has brought about a revolution in the health care system. The change from cost reimbursement came at a time when private insurers and employers also were flexing their buying power and pressuring hospitals to cut costs in order to reduce increases in health insurance premiums. These changes in the health care marketplace have had some positive, very positive, effects. However, we need to examine more closely the long term effects of some of these changes.

The Administration seems to have changed the rules of the game. We agreed to an increase in the DRG payments by market basket plus 1% when we supported passage of this legislation. Last year Congress reduced the payment to market basket plus one quarter percent. Now, for Fiscal Year 1986 we are experiencing a freeze, that is, no increase in hospital payment rates from the previous year. These spending reductions come at a time when the number of Medicare beneficiaries is exploding, not shrinking. In the next ten years the numbers of our elderly are expected to grow by 18 percent; the over 85 population by 51 percent. We will experience new strains on the program, even without budget cuts. The government has also drastically cut the Medicaid program, thus exacerbating the indigent care problem for hospitals. The government essentially is asking hospitals to provide the same or better quality health care services to more beneficiaries without increasing payment rates to providers of health care to cover even minimum inflation factors of hospital expenditures for labor and supplies.

The federal governments' policy for reimbursing hospitals under the Medicare program will have a "substantially depressive effect" on hospital profitability during the next two years, according to a study conducted by the consulting and research firm, ICF Incorporated. (Report attached) ICF projects that operating losses for 1985 among the 5,354 hospitals covered by the study, will equal $1.7 billion. These losses increase to $3.4 billion in 1986 and $2.7 billion for 1987. It should be noted that the study assumes a highly optimistic increase of market basket plus one quarter percent for 1986 and 1987. A key finding of the study shows 59% of hospitals will fail to earn operating revenues in excess of expenses in 1986. The study further projects that actual reimbursments for inpatient hospital admissions for the hospitals in the sample would be less in 1987 than in 1984, $34.7 versus $34.9 billion. Several of the leading hospital management companies, my own included, representing a significant portion of the hospital industry have experienced and are projecting relatively flat earnings for 1986.

Should the Gramm-Rudman-Hollings automatic cuts be implemented, hospitals will receive a reduction of 1% below the current freeze on March 1 and an additional 2% reduction in payments for FY 1987. Furthermore, the capital payment plan proposed by the Administration in its FY 1987 budget and to be implemented by regulation would reduce hospital payments by $456 million. Whatever operating margins hospitals may have enjoyed in 1984 are being quickly eroded by subsequent regulatory and congressional actions reducing Medicare payments to hospitals.

If we had frozen payments to hospitals over the last 10 years what improvements would we have sacrificed? How many life-saving Intensive Care Units, or Cardiac Care Units or Neonatal Units would not exist today? What about technological advances like the CAT Scanner and MRI? Would we have the same quality and quantity of health care we enjoy today? Absolutely not!! Do we really want a static or deteriorating health care system?

In the long term if government continues its current payment policies, quality of care in a significant number of hospitals will be adversely affected by:

- -- Lack of capital to obtain the latest technology
- -- Lack of capital to maintain and update the physical plant
- -- Lack of capital to support research and teaching

-- Reduced reimbursements which will not support all tertiary care functions

-- Lack of sufficient operating surplus (profit) will mean closing units, or closing entire hospitals.

Access to care will be similarly affected as hospitals will be unable to absorb or "shift" the cost of serving indigent patients. Hospitals will avoid exceedingly complex high cost cases that particularly in small hospitals can bankrupt a facility.

Rather than focusing on what is an appropriate "profit" based on insufficient and outdated data, Congress should focus on rewarding hospitals for the successes of the prospective payment system and keep its part of the deal made with hospitals, by giving them a fair rate of increase in payments for services provided to Medicare beneficiaries.

Conclusion

Hospitals understood the prospective payment law to be a contract. We have kept our part of the contract, and the system is working. However, if Congress unilaterally changes this contract by freezing or reducing hospital payments, then hospitals hardly can be expected to continue to endorse the program. Instead, you will have calls for the continuation of cost based reimbursement, with all of its perverse incentives and lose the opportunity to move forward with a program that has allowed the Medicare Trust Fund to remain solvent a decade longer than predicted just two years ago and has benefited private insurers, beneficiaries and employers as well.

Reducing hospital payments to shrink hospital "profits" will not reward hospital managers who have cut their costs by working with their staffs, physicians and patients to adapt to the new payment system. Instead hospitals will be forced to reduce their intensity and quality of services to Medicare beneficiaries, cut their staffs and wages, postpone replacement of equipment and plant modernization, increase prices to non-Medicare patients and increase charges to Medicare patients for non-covered services.

Breaking faith with hospitals after they have responded precisely as anticipated and desired under prospective payment is a sure way to undermine our support. We urge Congress to treat hospitals fairly, and increase payment rates equitably.

SIMULATION OF THE CONTINUATION OF CURRENT MEDICARE PAYMENT POLICY

This report summarizes the results of a simulation of community hospital financial results performed by ICF Incorporated using the Hospital Investment Simulation Model. The simulation projects the likely effects on hospital financial performance if current Medicare payment policies are continued. Table 1 summarizes hospital operating data predicted by the model.

TABLE 1

AGGREGATE OPERATING RESULTS FOR ACUTE INPATIENT COMMUNITY HOSPITALS IN NON-WAIVER STATES, 1984-1988*

	1984	1985	1986	1987	1988
		(billions of dollars)			
Revenues:					
Operating**	95.0	98.3	100.4	105.3	111.7
Philanthropy & Tax Contributions	3.2	3.3	3.5	3.7	3.8
Total Revenues	98.2	101.6	103.9	108.9	115.5
Expenses:	97.3	99.9	103.8	107.9	112.0
Income:					
Operating Income	-2.3	-1.7	-3.4	-2.7	-0.3
Total Income	+0.9	+1.7	+0.1	+1.0	+3.5

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* Numbers may not add to totals due to rounding.

** Patient revenue less contractual allowances and allowances for bad debt and charity care, plus other income.

The results above are projections for the 5,354 acute inpatient hospital facilities operating in states not under a waiver of Medicare reimbursement requirements in 1984. While the model predicts continued net profitability for the industry as a whole throughout the forecast period, there are substantial hospital operating losses in the 1984-1987 period. In fact, during the 1984-1988 period, the model predicts that hospital net income will be derived from tax contributions and philanthropy, which together offset operating losses. The balance of this report analyzes the reasons underlying this predicted performance pattern. Appendix A discusses the assumptions used by the model in producing this forecast.

I. The Impact of Medicare Reimbursement Policy on Hospital Financial Results

Based on the results of our simulation, we believe that the changing pattern of Medicare reimbursement rules is the predominant factor determining hospital financial results. Table 2 summarizes the effects of Medicare reimbursement on hospital financial performance.

TABLE 2

HOSPITAL REVENUES AND EXPENSES ATTRIBUTABLE TO MEDICARE REIMBURSEMENT FOR INPATIENT ADMISSIONS*

	1984	1985	1986	1987	1988
Revenues:					
Part A Inpatient	34.9	35.4	34.0	34.7	37.7
Other Operating[1]	60.1	62.9	66.4	70.6	74.0
Tax and Philanthropy Contributions	3.2	3.3	3.5	3.7	3.8
Total	98.2	101.6	103.9	108.9	115.5
Expenses	97.3	99.9	103.8	108.0	112.0
Income	0.9	1.7	0.1	1.0	3.5

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[1] Includes Medicare reimbursements for outpatient services and non-patient income less contractual allowances and allowances for bad debt and charity care.

* Numbers may not add to totals due to rounding.

Medicare revenues for each hospital were simulated by the model based on Medicare rules in effect in each year. In all years, a cost pass-through for capital is maintained as under current law. Direct teaching payments are frozen at the 1984 level as specified by current regulations. Revenues for 1984 were estimated based on actual hospital case mix data derived from the HCFA MEDPAR file for 1984. For 1985 and 1986, DRG payments are based on the payment rate freezes in effect under Medicare regulations. For 1987 and beyond, payments are assumed to increase at the present statutory rate of increase of one-quarter percent in excess of the projected "market basket".

In attempting to reach conclusions about the effect of the Medicare Prospective Payment System (PPS), a number of published analyses draw conclusions based on a comparison of current PPS reimbursements to reimbursements that would have been obtained under the prior retrospective reimbursement scheme. We believe these analyses to be flawed by their inability to control for so-called cost-shifting in the prior law reimbursement base. Under prior law, exclusions and limitations on reimbursable costs led most analysts to conclude that Medicare reimbursements failed to cover the fully allocated costs of treating Medicare patients. To the extent that this was true, simple "old law, new law" comparisons would substantially overstate hospital profitability.

A preferred means of attacking this problem would be to allocate total inpatient hospital costs on the basis of Medicare v. non-Medicare patient days, adjusted for the extent to which Medicare case mix implies higher variable costs. Unfortunately, meaningful disaggregations of inpatient and outpatient fixed and variable costs are unavailable in existing data sets. Hence, while such an analysis could be performed on a hospital-by-hospital basis, it is not a practical approach to reaching the question of nationwide effects.

Notwithstanding these limitations, however, we believe it is clear from the results of our simulation that Medicare reimbursement policy will have a substantially depressive effect on hospital profitability during the 1986-1987 period. According to our projections, reimbursements for inpatient hospital admissions in the 5,354 hospitals for which projections were made will total $34.7 billion in 1987, a level negligibly smaller than the $34.9 billion reimbursement level projected for 1984. In a period in which total expenditures of these hospitals rises by $10.6 billion, or by 11 percent, this effective reimbursement lid must, perforce, reduce the profitability of PPS payments. In all, while the conversion to PPS in 1984 may well have increased the initial level of Medicare reimbursements for many hospitals, the effect of the payment freeze between 1985 and 1986 has substantially eroded any such increases.

To illustrate this effect, we have prepared Table 3, which compares average hospital profitability based on a number of assumptions of what initial Medicare profit margins may have been at the point of PPS conversion.

The table illustrates the effect of flat average reimbursements in an era of rising costs. If reimbursement rates are held constant and costs rise 11 percent, a hospital enjoying a 10 percent profit margin in 1984 would only break even in 1987. Hospitals whose base DRG rates were less than 10 percent higher than their fully allocated costs would, by 1987, be losing money on Medicare inpatient reimbursements.

As discussed earlier, it is not possible to disaggregate base year profitability of Medicare payments using nationwide data sources. The Hospital Investment Simulation Model does, however, predict overall profitability for individual hospitals on a year-by-year basis for the 5,354 hospitals under study. Table 4 presents the distribution of hospitals by overall operating profit margins between 1984 and 1988.

TABLE 3

COMPARISON OF 1984 AND 1987 PROFIT MARGINS USING AVERAGES OF HOSPITAL DATA

Hypothetical 1984 Profit Margin	Resultant 1987 Profit Margin
20%	12%
15%	5%
10%	--
5%	-6%
0%	-11%

TABLE 4

DISTRIBUTION OF HOSPITALS BY RANGE OF OVERALL OPERATING PROFIT MARGINS, 1984-1988 UNDER CURRENT MEDICARE LAW

Number of Hospitals with Margins in Range	1984	1985	1986	1987	1988
Breakeven or Losing Money	3,166	2,793	3,161	2,924	2,575
0% to 5%	1,142	1,179	921	872	988
5% to 10%	541	640	525	566	674
10% or more	505	742	747	992	1,117

As Table 4 suggests, the Hospital Investment Simulation Model predicts that the majority of the hospitals under study will lose money on an operating basis in FY 1985-1987.

In 1984, during the conversion to PPS, 59 percent of all hospitals in non-waiver states were losing money on an operating basis. During 1985, this situation improved somewhat; the percentage of hospitals losing money or breaking even on an operating basis is predicted to fall to 52 percent. Beginning in 1986, however, that trend reverses again; the effects of the FY

1985-1986 DRG payment freeze drive 59 percent of the hospitals below profitability in 1986. In 1987, this trend begins to reverse again, as the assumed 1987 DRG payment rate increase of "market basket plus one quarter" takes effect. With a further increase assumed for 1988, the percentage of money-losing or break-even hospitals falls to 48 percent under the assumption that PPS rates continue to rise under the current law schedule.

As indicated in Table 1, sources of revenue other than operations offset these operating losses, on average, for the nation as a whole. As Table 5 shows, however, even when these revenue sources are included, a significant number of hospitals are predicted to lose money over the period under current Medicare reimbursement policy.

TABLE 5

NET INCOME AS A PERCENT OF TOTAL REVENUES FROM ALL SOURCES, 1984-1988

Number of Hospitals with Total Margin:	1984	1985	1986	1987	1988
Breakeven or Losing Money	2,455	2,139	2,576	2,380	2,008
0% to 5%	1,478	1,367	1,167	1,043	1,131
5% to 10%	815	966	713	767	890
Over 10%	606	882	898	1,164	1,325

Conclusion

Based on our simulation, we believe that the net effect of Medicare inpatient reimbursement policies in hospitals in non-waiver states will, by 1986, have a negative impact on hospital profitability. While anecdotal evidence exists that specific hospitals or specific regions were favorably affected by the transition to PPS, subsequent legislative and regulatory developments have held down PPS rates to the point that early gains may have already been offset. The model's prediction of a reversal of this trend beginning in 1987 is, of course, heavily dependent on the assumption that no further program reductions from the baseline would be enacted or adopted through regulation. Given the present budgetary environment, that assumption is undoubtedly optimistic.

Medicare reimbursement changes alone, of course, do not explain the overall drop in profitability predicted by the model. A second substantial factor is the rapid decline in hospital utilization assumptions underlying the model. We have assumed that these utilization declines, as expressed in inpatient days per 1,000 population, will level off through 1991 at 1984 utilization rates. This may or may not be a second optimistic assumption.

Third, the model's predictions about overall hospital profitability are based on the assumption, exhibited in Tables 1 and 2, of growing philanthropic contributions and government tax revenue support. Between 1984 and 1988, we assume such contributions will rise by 19 percent as a result of holding the 1984 base of contributions constant in real terms. Given the status of state and local government finances, this may or may not be a valid assumption.

Finally, the model's assumptions about non-Medicare revenues (including Medicare revenues for outpatient services) are generally based on the premise that non-Medicare margins can be maintained at historical levels throughout the balance of the decade. Given the highly competitive market for hospital services and the growing phenomenon of Preferred Provider Organizations (PPOs) and other alternative health care financing arrangements seeking substantial charge discounts in the hospital marketplace, this assumption is undoubtedly optimistic as well.

In all, we believe the projections made by the Hospital Investment Simulation Model will tend, all other things being equal, to conservatively estimate the negative impact of Medicare reimbursement policy on hospital profitability.

APPENDIX A

ASSUMPTIONS USED IN THE ICF HOSPITAL INVESTMENT SIMULATION MODEL

(Runs of 2/86)

HOSPITALS FORECAST

-- Hospitals included in these tables are only those hospitals in states without Medicare waivers in 1984.

ECONOMIC ASSUMPTIONS

-- Shown in Table A-1

UTILIZATION ASSUMPTIONS

-- The model uses actual hospital utilization rates up until 1984. After 1984, utilization rates (patient days per 1,000 population) for the under-65 population are assumed to remain constant at the 1984 level for both non-HMO and HMO enrollees. However, the growth in the number of persons enrolled in HMOs causes overall average utilization to decline over the period.

-- Utilization for the over 65 population is also held constant at 1984 rates, but length of stay can decline due to increased HMO enrollment and due to hospital response to prospective payment. Hospitals reduce expenses by cutting Medicare length of stay to a minimum of 7 days.

CAPITAL REQUIREMENTS ASSUMPTIONS

-- The model assumes that hospitals renovate or replace every 25 years, and that useful life for smaller modernization projects is ten years. Therefore, 4 percent of all hospital beds are eligible for renovation or replacement each year. (Completion of these projects, however, depends upon financial ability.)

-- It is assumed that hospitals complete some investment for modernization each year, the total amount of which depends on the number of beds ($3,000 per bed in 1981, inflated over time).

REVENUE ASSUMPTIONS

-- Payment for Medicare beneficiaries is determined using prospective payment beginning in 1984. Published HCFA rates are used in 1984 and 1985. It is assumed that rates are frozen between 1985 and 1986 and inflated by market basket plus one-quarter of a percent in each year after 1986. These runs assume no change in the indirect teaching allowance and a freeze in the direct teaching payment at 1984 levels. New wage indices are used beginning in 1986.

- -- All runs assume a continuation of the Medicare pass through for capital costs.
- -- Hospitals respond to the prospective payment system by reducing expenses. They do this by cutting length of stay for Medicare patients and by reducing the number of full time equivalent employees per bed. The model specifies a minimum length of stay and FTEs per bed.

INVESTMENT ASSUMPTIONS

- -- The ability to complete desired investment is constrained by a hospital's financial condition. In order to obtain financing, it is assumed that a hospital must maintain a debt service coverage (DSC) ratio of 2.0. In addition, hospitals must have sufficient internal funds to make an equity contribution.
- -- It is also assumed that hospitals will finance renovation/replacement and expansion projects with long-term debt if possible, even if sufficient funds are available to finance the project using its own funds. If, however, the hospital cannot meet the DSC ratio requirements, it will finance a portion of the project with internal funds. All investment projects are assumed to be completed with internal funds.

TABLE A-1

ECONOMIC ASSUMPTIONS
1981-1990

	Percent Change			
	CPI	Hospital Market Basket	Hospital Wage Rate	Long-Term Interest Rate
1981	10.20	11.70	12.30	14.17
1982	6.00	9.60	11.20	13.79
1983	3.00	6.40	7.40	12.04
1984	3.40	5.20	5.50	12.71
1985	3.90	4.90	4.90	11.86
1986	4.70	5.90	5.90	11.92
1987	5.30	7.00	7.40	12.07
1988	5.00	6.80	7.40	12.38
1989	4.60	6.60	7.20	11.95
1990	4.20	6.30	7.00	11.25

SOURCE: Medicare Trustees Report and DRI projections.

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. OWEN. Thank you, Mr. Chairman. My name is Jack Owen. I am the executive vice president of the American Hospital Association and director of the Washington office of the American Hospital Association. My statement has been prepared and sent to you along with a number of tables of statistics regarding hospital patient revenue by region, by size of hospital, and by ownership, patient and nonpatient revenue, and I won't go into those. They are available. I would be happy to answer questions about them.

I would like to comment a little bit on what we as a national hospital association see as the problems that we are facing in this whole program, and some of it is very similar to what Mr. Howard just commented on.

First of all, I think the whole purpose of the prospective pricing system when we started was to provide predictability—predictability for the Government and the hospitals—and the concern in 1982 and 1983 was that the trust fund was going to be bankrupt by 1987 and that something had to be done to correct the rising hospital costs and to solve the trust fund problem.

In 1984, we agreed as the hospital industry to move toward the prospective—in 1983—toward the prospective pricing system which would be implemented in fiscal year 1984. And those agreements were based on unaudited costs plus a market basket and 1 percent for technology. And the purpose of that was to get it moving quickly. And I think it is important to understand that the Government set the price. The hospitals didn't set the price; the Government set the price, and hospitals were told, "You can sink or swim." And we are here now defending those that were able to swim. And as Senator Baucus rightly pointed out, there are a lot of hospitals out there who are sinking, and we have got to take a look at them as well.

The Office of Management and Budget expected an increase in admissions of at least 2 percent, and even with that increase in admissions, the estimated budget for the hospital portion of Medicare was $40.1 billion, and when we got through with 1984, we actually spent only $37.9 billion, or $2.2 billion less than what was anticipated. And how did it happen?

Well, Sam pointed out some of the reasons. Hospitals took seriously that the Government's commitment was to do something and to reward efficiencies, and they reduced personnel, a one-time event, and that reduction in personnel was 3.3 percent, it turned out. I have been in this business for 30 years and this is the first time that the American Hospital Association, keeping statistics, showed an actual reduction in the number of personnel.

They lowered the length of stay, and with the help of some PRO's they reduced admissions for procedures, which could be done on an outpatient basis. What credit have the hospitals gotten for doing the job that the Government asked of them? In 1985, the market basket was reduced from 6 percent to 4 percent by changing weights, and Congress cut the technology factor by three-quarters of 1 percent to one-quarter of 1 percent, and in 1986 the rate has been frozen at the 1985 level, and we face a 1-percent reduction under the Gramm-Rudman-Hollings Act for the last 7 months.

In addition, educational payments have been cut, and it appears that capital payments will be reduced as well. And I am here today to explain why half the hospitals had a profit on Medicare in 1984, and there is another half which had a loss, as you can see from the statistics there.

Mr. Chairman, the issue is not what hospitals did in 1984, but what is happening in 1986, and what is going to happen in 1987. Averaging rates will continue the problem of winners and losers. Going back to cost reimbursement, we both know, won't work. We need a fair rate with a market basket update. If not, it is only going to be a matter of time before accessibility and quality are being affected, and we are going to have more hearings by the Senate Committee on Aging as to why hospitals are letting patients go quicker.

You made one comment, Mr. Chairman, about deregulation. I wish it were true, but I don't see deregulation occurring. What I see happening is tighter and tighter regulations, and as long as the Government is setting the price, changing the rules without offering even adequate hearings for our hospitals, we are a long way from a deregulated industry.

Thank you for giving me the opportunity to express our concerns.

Senator **Durenberger**. Let me just clarify that latter point. When I speak of deregulation, I am talking about economic deregulation. I am not talking about the fact that we don't send out regulations and you don't have to——

Mr. **Owen**. No; I know that, but I think as long as you set the price, that is economic regulation.

Senator **Durenberger**. No. But what we are doing by setting the price is eliminating the subsidies. We are not—and that is economic deregulation. We are no longer billing the long distance users for the rural side. So in this case we are trying not to bill the payers for the unpaid. I think that is part of what is going on. Do you disagree?

Mr. **Owen**. I would like to—yes, I would—I would like to debate that with you, but maybe this is not the place to do it.

Senator **Durenberger**. No. Just that you can add it, and I won't ask you any questions later. [Laughter.]

Are we not reducing because——

Mr. **Owen**. We have reduced some regulations, I would agree with you, and I think it has changed the way that the hospitals operate.

Senator **Durenberger**. Are our hospitals—let me phrase it this way—are our hospitals still able to cost shift the way they were 3 years ago? Take from Medicare to pay for Medicaid, take from the other third-party payers to take care of all the uncompensated care, because if they are, that is one of the values of this hearing and this issue of profit.

Mr. **Owen**. They're not able to cost shift the way they did because of the private sector, the way they have moved into the HMO and the PPO and the negotiations that take place so that everybody is setting a price, and the price based on the Medicare rate——

Senator DURENBERGER. People are paying only for what they get, right?

Mr. OWEN. Well, that——

Senator DURENBERGER. Medicare is doing that, and the private side is also doing that. Isn't that——

Mr. OWEN. But there are people who are not paying for what they get. How do we take care of those people?

Senator DURENBERGER. Well, that is what I mean by economic deregulation. We are not taking care of those——

Mr. OWEN. But if we were completely unregulated, we would have some cost shift, because every industry does that. Bad debts, breakage, loss, that is part of the price you pay when you buy a suit, or when you buy a car, or anything else. We are not able to do that because we can't set the prices, and that is one of the fallacies in the report. The IG pointed out what the cost is in the particular case versus what Medicare paid for that particular case, not what the total revenues of an institution are.

Senator DURENBERGER. OK. All right. Mr. Lipson.

[The prepared statement of Mr. Owen follows:]

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STATEMENT
OF THE
AMERICAN HOSPITAL ASSOCIATION

On behalf of its 6100 institutional members, the American Hospital Association (AHA) welcomes this opportunity to testify before the Finance Committee's Health Subcommittee on the subject of hospital operating margins. Recent news coverage of hospital financial performance has resulted in an inaccurate and misleading picture, and has been based on incomplete data from sources that have not been made available for public review. By contrast, data maintained by the AHA have been regularly published for many years, and are based on established surveys, conducted using methods that are available for public scrutiny. These data provide a much more complete picture of hospital performance that is both varied and complex--performance that is experiencing revolutionary change and enormous uncertainty.

The most current data on hospital operating margins collected by the AHA show changes in overall financial performance between 1984 and the first ten months of 1985, and provide clear evidence of variation in hospital financial performance during 1984. Most of the statistics included in the attached tables, and discussed in this statement, describe net operating margins for all categories of patient services. Occasionally, data on total net margins will be presented. The difference between the two is fairly simple: the net patient operating margin reflects the extent to which revenues from patient services are, by themselves, sufficient to cover the cost of care provided to hospital patients; the total margin includes revenues from patient services as well as revenues from other sources, e.g., endowments, investments, and non-patient services. For the purpose of evaluating the adequacy of payment, the net patient margin is the more appropriate measure, since hospitals should be able to generate sufficient revenue from patient care to cover their essential functions. Unfortunately, certain information of interest to the members of this Subcommittee--specifically, recent and reliable data on the difference between payments for and costs of treating Medicare patients--are not available due to the inability of the Health Care Financing Administration (HCFA) to process Medicare financial information for analysis.[1] The most current HCFA data on actual payments and costs for hospital services are from 1983--totally useless in examining current trends. The AHA data on overall hospital financial performance, however, do shed some light on the adequacy of Medicare payments to hospitals.

Although overall hospital financial performance in 1984 was stronger than at any time in the past, net patient margins were still below 2.5 percent. Historically, net patient margins have been very low, and revenues from patient care often have been less than operating expenses. In fact, it was not until 1980 that revenues from patient services exceeded the cost of patient care. The stronger financial performance of recent years could, consequently, be interpreted as an indication that hospital finances are being put on an increasingly stable footing. If the financial performance of hospitals during 1984 is examined more closely, however, it appears to be more of a temporary aberration than a permanent shift. When placed in the context of changes in financing and payment that have occurred in both the public and private sectors, this conclusion receives additional support.

Much of the strong 1984 performance can be attributed to unusual third and fourth quarters of the year. More recent data suggest that operating margins may have peaked in late 1984 or early 1985, and since then have been level or declining. Comparing the first three quarters of the past two years, net patient operating margins averaged 2.2 percent in 1984 and 2.1 percent in 1985. In comparing the third quarters alone, net patient operating margins fell from 2.0 percent in 1984 to 1.4 percent in 1985. There are several possible explanations for this pattern, including the continued down-turn in hospital admissions, the nominal increase in payments to hospitals by Medicare (along with a growing increase in amounts paid for goods and services) as hospitals with fiscal years beginning in July began their second PPS years, and continued competitive pressures from private payers.

HHS Inspector General's Report

AHA data for 1984, which cover four fifths of the nation's community hospitals and both Medicare and non-Medicare revenues and costs, differ substantially from the partial data on Medicare operating margins that recently have been reported by the news media. Media stories often are based on the experience of a single hospital, whereas data collected by the AHA reflect the experience of a large representative sample of hospitals. As discussed in the next section, operating margins vary widely among hospitals. The experience of a single hospital or a non-representative sample of hospitals cannot be used to gauge the experience of the entire industry, nor do average margin figures accurately reflect the experience of a single hospital or all hospitals.

Several news accounts of hospital financial performance have cited a report by the HHS Office of the Inspector General (OIG). The authors of this report, which was based on a non-representative sample of hospitals, claim to have found an average "profit" of 14.2 percent on Medicare patients for hospital fiscal years ending in 1984. The hospitals included in the study were completing their first year under the prospective pricing system, and had not yet felt the impact of the less-than-2-percent increase in prices for the second prospective pricing year and the freeze in prices for the third prospective pricing year.

Although the OIG report focused on the difference between Medicare costs and revenues, rather than overall hospital operating margins, the report has several fundamental limitations which render its conclusions invalid. First, the report was not based on a representative sample of hospitals. The report included data from a disproportionately large number of hospitals located in Census Regions 3, 7, and 9. Table 7, using AHA data, reveals that an unusually high percentage of hospitals in these three regions had an unusually strong financial performance that has not occurred in other regions. Thus, the OIG report overstates nationwide hospital margins.

Second, the report did not examine the true difference between operating revenues and operating costs. Instead, the authors compared operating costs to operating revenues plus the return on equity paid to investor-owned hospitals. The result is a substantial and misleading overstatement of the "operating margin," particularly if the purpose of the study was to evaluate the adequacy of payment under PPS. And because investor-owned hospitals are more common in the census regions included in the report, the report further overstates national performance.

Finally, the extent to which the OIG report does not reflect national experience under PPS can be assessed by comparing the estimated Medicare margin reported by the OIG to the net patient margin for 1984 reported by hospitals participating in the AHA's Annual Survey. Medicare accounts for between 30 and 40 percent of the average hospital's revenue. If hospitals generate a Medicare margin of 14 percent and an overall patient margin of 2.2 percent, they would have had to experience a loss of 4.2 percent on non-Medicare patients. Such losses would be unprecedented and implausible. The AHA concludes that the OIG report is an inadequate analysis of hospitals' financial situations and should not be used for any policy-making purposes.

Need for an Operating Margin

One of the most troubling aspects of the news coverage given to the OIG report is the emphasis on "excess" profits without giving consideration to hospitals' need for an operating margin if Medicare's PPS is to be successful. The principal purpose of PPS was to create a positive incentive for hospital managers to improve the efficiency with which hospital services are produced and used. PPS creates these incentives by putting the hospital "at risk" for the difference between costs and the prices established for the 469 DRGs. Under PPS, hospital managers are at risk for any factors affecting costs, including those beyond the control of the manager. Changes in volume and fluctuations in the number of "outlier" or severely ill and extraordinarily costly patients can cause significant shifts in average costs. In small hospitals, a single outlier patient can make the difference between breaking even and running a substantial deficit. Under the old system of cost-based reimbursement, hospital managers were at least partially protected from these risks. Under PPS, the only protection against these risks is provided by the hospital's reserves and operating margin.

Added to the risks inherent in DRG-based prospective pricing, is the uncertainty associated with implementation of a radically new payment system. Because of the vagaries and uncertainties of the federal budget process, hospital managers are compelled to budget with little advance knowledge of prices that will be paid for their services or the policies under which they will operate. Operating margins experienced during the first year of operation under the PPS were undoubtedly due, in part, to the efforts of managers to provide a margin of safety, given the uncertainties surrounding the implementation of the new payment system.

VARIATION IN HOSPITAL PERFORMANCE

Much attention to hospital financial performance has focused on overall performance or the performance of the "average" hospital. As Mark Twain noted, however, a man with one foot in a bucket of boiling water and one foot in a bucket of ice water should be, on average, comfortable. The problem with averages is that they often conceal as much as they reveal. The data on operating margins are no exception.

The strong financial performance of the "average" hospital during 1984 conceals the fact that over half of all hospitals had negative operating margins (see Table 3). In over one fifth of all hospitals, patient revenues fell short of operating costs by 6 percent or more; that is, the operating deficit was 6 percent or greater. By contrast, slightly over one quarter of all hospitals earned positive operating margins of 3 percent or more.

The pattern of losses in some hospitals and positive margins in others is repeated in most groups of hospitals: urban; rural; those categorized by bed size; and those located in each of the census regions. The experience of hospitals in each group is not, however, identical. Rural hospitals, for example, are more likely to experience losses than urban hospitals, as are small hospitals, and hospitals located in the Northeast. The reasons for the variations in performance have not been clearly identified, but appear to include:

- unanticipated reductions in the number of admissions;
- changes in case mix that may not be adequately recognized by PPS;
- differences in the payer mix of hospitals that affect the ability of hospitals to subsidize unsponsored care;
- increases in the volume of uncompensated care provided by hospitals that are not offset by state or local tax appropriations; and
- increased pressure from private payers to obtain discounts or enter into payment arrangements that limit hospital revenues.

Obviously, only some of these factors are related to PPS. However, PPS is expected to result in significant shifts in revenue, and may exacerbate differences in hospital financial performance. To some extent, this is simply the result of the intended effect of incentives created by PPS. By creating incentives to improve efficiency, PPS should lead to improved financial performance by those hospitals that respond to the incentives, while the financial performance of those hospitals that do not respond to the incentives will deteriorate.

A key policy issue for this Subcommittee is whether PPS is producing the effect on hospital finances that is desired. One of the conclusions that must be drawn from the operating margin data is that the payment system, as it moves to nationally-based prices, is rewarding or penalizing hospitals without regard to their relative efficiency and without regard to the severity of illness among patients.

The reasons for variations in financial performance should be identified. The AHA is committed to refining the new payment system in an effort to make certain that payments are both adequate and equitable.

LOOKING AHEAD

While the data that have been presented address operating margins in 1984 or during the first ten months of 1985, the critical decisions facing Congress and the Administration do not concern past payments. The real issue is the future financial viability of the nation's hospitals. Several developments are likely to cause both current and future performance to differ substantially from past performance.

First, since the implementation of PPS, prices have been increased by less than that necessary to reflect the effects of inflation on hospital costs. Prices for the remainder of 1986 will be frozen or even rolled back by 1 percent. By contrast, during federal Fiscal Years 1985 and 1986, HCFA estimates that inflation has increased the cost of the labor, goods, and services needed by hospitals to care for patients by more than 10 percent. Thus, in real terms, Medicare hospital payments have fallen by more than 8 percent over FYs 1985 and 1986. Recent reports suggest that the

Administration plans at this time to increase prices for federal FY 1987 by no more than 2 percent, an amount substantially less than inflation expected next year. Any operating margin that was earned on Medicare payments in 1984 probably will be absorbed by these reductions in payment, substantially weakening or subverting the positive incentives of PPS.

Second, hospital utilization has changed substantially since 1982. Total admissions have declined, and hospitals report significant increases in the complexity and severity of illness of patients admitted to hospitals. To some degree these changes may result in higher payments if the DRG mix of the hospital changes. However, as was noted above, the ability of DRGs to reflect the cost of resources used in caring for patients admitted to hospitals is limited. Particularly in small and rural hospitals, changes in utilization and costs appear to have outstripped increases in payments or revenues. Although figures for Medicare alone are not available, overall average per-case costs in hospitals operating fewer than 50 beds rose by 12.2 percent in the year ending October 31, 1985. Since this change reflects both Medicare and non-Medicare patients, the result may well have been a substantial deterioration in the financial position of smaller hospitals--a prediction consistent with the margin figures reported above.

Hospitals will make an effort to compensate for these reductions by improved productivity and more effective use of inpatient services. However, the amount of improvement that can be achieved is not unlimited. Shorter stays, more conservative use of ancillary services, greater use of home health and subacute care, and more extensive use of outpatient services all can contribute to more cost-effective medical care. However, hospital efforts to improve efficiency also may lead to higher costs for each inpatient stay because less severely ill patients increasingly receive their care outside hospitals. The sharp reduction in inpatient admissions since 1982 appears associated with faster growth of the average hospital cost per admission, even though total costs are now rising by less than 5 percent per year. From the perspective of the Medicare program, total expenditures have fallen substantially from projected levels. Before further cuts in payment are made, the adequacy of current payment levels must be assessed.

In 1982, at the time that the Tax Equity and Fiscal Responsibility Act was enacted, projected Medicare expenditures were $46.5 billion in FY 1984. The 1984 annual report on the status of the Medicare Trust Fund revised the FY 1984 projection to $44.5 billion, a reduction of $2.0 billion, and projected expenditures of $52.0 billion in fiscal year 1985, and $57.0 billion in FY 1986. Actual expenditures have been consistently below these projection: $42.1 billion in 1984 and $48.7 billion in 1985. The most recent report of the trustees projects expenditures of $49.6 billion in 1986. Thus, over the three years from 1984 through 1986, total savings to the federal government are now estimated at more than $13 billion.

CONCLUSION

Although hospital operating margins recently have attracted considerable attention, much of the public discussion has focused on incomplete and non-representative data and has failed to acknowledge wide variations in hospital operating margins. Data from the AHA's Annual Survey for 1984 indicates that more than half of all hospitals experienced operating deficits based on patient services revenues. More recent data confirm the variability of hospital financial performance, and more importantly, provide evidence that 1984 operating margins are likely to be temporary and are already declining. It is critical that current, reliable data on operating margins be available to policy makers. Because prices have increased only 2 percent during federal FYs 1985 and 1986, any operating margins that were earned in 1984 will be substantially reduced, and in many cases will disappear.

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[1] The AHA has, however, received some Medicare data from the District of Columbia Hospital Association (DCHA), showing that in 1984 the District of Columbia's hospitals received $219 million in Medicare payments and incurred cost of $224 million in treating Medicare patients. Thus, hospitals in the District of Columbia suffered a $5 million loss on Medicare patients, or received only 98 percent of costs. DCHA projections show that percentage dropping to 90 percent in the years ahead.

Hospital Financial Margin Data
from the
National Hospital Panel Survey
and the
1984 Annual Survey

Department of Hospital Economic Performance
Office of Public Policy Analysis

January 31, 1986

Basic Finding:

Although many reports focus on overall margins for the industry as a whole, the AHA 1984 Annual Survey shows substantial variation in hospital financial performance, with operating revenues falling below expenses in a significant proportion of hospitals in 1984. This is true overall and for all basic categories of hospitals.

Method and Data Source:

Tables 1 and 2 summarize the most current data available on hospital revenue margin trends from the National Hospital Panel Survey, a statistically representative sample of community hospitals. Data are presented for the nation, regions, and bed-size groups.

Tables 3 through 7 use data from 4,141 community hospitals who reported patient margin data on the 1984 Annual Survey. This data base excludes 1,494 hospitals who reported incomplete patient margin data and 67 hospitals whose reported margins were more than 3 standard deviations from the patient margin mean.

This set of hospitals represents 73 percent of the 5,702 community hospitals in the 1984 Annual Survey universe. The results accurately characterize margin variation within the 73 percent sample, and clearly document that margins vary widely across hospitals. However, one cannot directly project these results to the universe of all hospitals without considering the unknown performance of the non-responding hospitals.

The patient margin is defined as net patient revenue minus total expenses, expressed as a percent of net patient revenue. Patient margins differ from total margins because patient margins exclude non-operating revenue and non-patient operating revenue (such as that from gift shops and cafeterias). The patient margin reflects the ability of hospitals to cover expenses using revenues from patient services.

TABLE 1
HOSPITAL REVENUE MARGINS: 1983-1985
REGIONAL VARIATIONS

	YEAR-TO-DATE OCTOBER			PERCENTAGE POINT CHANGE	
	1983	1984	1985	1983-84	1984-85
TOTAL NET MARGIN					
REGION I	3.2%	4.8%	6.1%	1.6	1.3
REGION II	1.1%	2.0%	2.7%	0.9	0.7
REGION III	6.6%	8.3%	7.4%	1.7	-0.9
REGION IV	5.7%	6.7%	6.6%	1.0	-0.1
REGION V	7.5%	7.6%	8.7%	0.1	1.1
REGION VI	5.4%	6.8%	6.1%	1.4	-0.7
REGION VII	9.1%	8.4%	8.1%	-0.7	-0.3
REGION VIII	7.8%	5.3%	7.0%	-2.5	1.7
REGION IX	7.4%	9.1%	8.3%	1.7	-0.8
ALL REGIONS	5.6%	6.5%	6.5%	0.9	0.0
NET PATIENT MARGIN					
REGION I	-0.9%	0.7%	2.1%	1.6	1.4
REGION II	-3.6%	-2.5%	-2.0%	1.1	0.5
REGION III	2.0%	3.6%	2.2%	1.6	-1.4
REGION IV	1.8%	2.8%	2.6%	1.0	-0.2
REGION V	2.6%	2.7%	3.8%	0.1	1.1
REGION VI	1.4%	2.2%	1.4%	0.8	-0.8
REGION VII	5.5%	4.5%	3.9%	-1.0	-0.6
REGION VIII	4.5%	1.6%	2.9%	-2.9	1.3
REGION IX	4.0%	5.8%	4.7%	1.8	-1.1
ALL REGIONS	1.6%	2.4%	2.2%	0.8	-0.2

NET NON-PATIENT MARGIN (TOTAL NET - NET PATIENT)

REGION I	4.1%	4.1%	4.0%	0.0	-0.1
REGION II	4.7%	4.5%	4.7%	-0.2	0.2
REGION III	4.6%	4.7%	5.2%	0.1	0.5
REGION IV	3.9%	3.9%	4.0%	0.0	0.1
REGION V	4.9%	4.9%	4.9%	.0	.0
REGION VI	4.0%	4.6%	4.7%	0.6	0.1
REGION VII	3.6%	3.9%	4.2%	0.3	0.3
REGION VIII	3.3%	3.7%	4.1%	0.4	0.4
REGION IX	3.4%	3.3%	3.6%	-0.1	0.3
ALL REGIONS	4.0%	4.1%	4.3%	0.1	0.2

SOURCE: National Hospital Panel Survey, American Hospital Association, Copyright 1986.

TABLE 2
HOSPITAL REVENUE MARGINS: 1983-1985
VARIATIONS BY HOSPITAL SIZE

	YEAR-TO-DATE OCTOBER			PERCENTAGE POINT CHANGE	
	1983	1984	1985	1983-84	1984-85
TOTAL NET MARGIN					
LESS THAN 25 BEDS	5.1%	-7.4%	-6.5%	-12.5	0.9
25 TO 49 BEDS	6.5%	5.0%	3.6%	-1.5	-1.4
50 TO 99 BEDS	6.3%	6.7%	5.5%	0.4	-1.2
100 TO 199 BEDS	6.6%	7.6%	7.1%	1.0	-0.5
200 TO 299 BEDS	6.0%	7.3%	7.0%	1.3	-0.3
300 TO 399 BEDS	5.3%	6.7%	6.8%	1.4	0.1
400 TO 499 BEDS	5.5%	5.4%	6.0%	-0.1	0.6
500 OR MORE BEDS	4.8%	5.9%	6.5%	1.1	0.6
ALL SIZES	5.6%	6.5%	6.5%	0.9	0.0
NET PATIENT MARGIN					
LESS THAN 25 BEDS	-0.3%	-12.5%	-12.0%	-12.2	0.5
25 TO 49 BEDS	3.7%	2.2%	0.5%	-1.5	-1.7
50 TO 99 BEDS	2.8%	3.3%	1.8%	0.5	-1.5
100 TO 199 BEDS	3.5%	4.3%	3.6%	0.8	-0.7
200 TO 299 BEDS	2.4%	3.3%	2.8%	0.9	-0.5
300 TO 399 BEDS	1.7%	3.3%	3.2%	1.6	-0.1
400 TO 499 BEDS	0.9%	0.8%	0.9%	-0.1	0.1
500 OR MORE BEDS	-0.4%	0.7%	1.1%	1.1	0.4
ALL SIZES	1.6%	2.4%	2.2%	0.8	-0.2
NET NON-PATIENT MARGIN (TOTAL NET MARGIN - NET PATIENT MARGIN)					
LESS THAN 25 BEDS	5.4%	5.1%	5.5%	-0.3	0.4
25 TO 49 BEDS	2.8%	2.8%	3.1%	-0.0	0.3
50 TO 99 BEDS	3.5%	3.4%	3.7%	-0.1	0.3
100 TO 199 BEDS	3.1%	3.3%	3.5%	0.2	0.2
200 TO 299 BEDS	3.6%	4.0%	4.2%	0.4	0.2
300 TO 399 BEDS	3.6%	3.4%	3.6%	-0.2	0.2
400 TO 499 BEDS	4.6%	4.6%	5.1%	0.0	0.5
500 OR MORE BEDS	5.2%	5.2%	5.4%	0.0	0.2
ALL SIZES	4.0%	4.1%	4.3%	0.1	0.2

SOURCE: National Hospital Panel Survey, American Hospital Association, Copyright 1986.

TABLE 3
PATIENT MARGIN DISTRIBUTION BY HOSPITAL BED SIZE
ALL HOSPITALS

	6%+ DEFICIT	3%-6% DEFICIT	0%-3% DEFICIT	0%-3% PROFIT	3%-6% PROFIT	6%+ PROFIT	TOTAL
NUMBER							
6 TO 49	318	88	115	104	63	70	758
50 TO 99	256	134	190	180	95	117	972
100 TO 199	142	122	192	211	163	142	972
200 TO 399	91	94	198	260	146	150	939
400 OR MORE	80	53	90	99	81	97	500
ALL SIZES	887	491	785	854	548	576	4141
PERCENT							
6 TO 49	42.0%	11.6%	15.2%	13.7%	8.3%	9.2%	100.0%
50 TO 99	26.3%	13.8%	19.5%	18.5%	9.8%	12.0%	100.0%
100 TO 199	14.6%	12.6%	19.8%	21.7%	16.8%	14.6%	100.0%
200 TO 399	9.7%	10.0%	21.1%	27.7%	15.5%	16.0%	100.0%
400 OR MORE	16.0%	10.6%	18.0%	19.8%	16.2%	19.4%	100.0%
ALL SIZES	21.4%	11.9%	19.0%	20.6%	13.2%	13.9%	100.0%

SOURCE: 1984 Annual Survey of Hospitals, American Hospital Association, Copyright 1985.

TABLE 4
PATIENT MARGIN DISTRIBUTION BY HOSPITAL BED SIZE
URBAN HOSPITALS

	6%+ DEFICIT	3%-6% DEFICIT	0%-3% DEFICIT	0%-3% PROFIT	3%-6% PROFIT	6%+ PROFIT	TOTAL
NUMBER							
6 TO 49	31	8	24	17	14	14	108
50 TO 99	43	35	47	53	29	52	259
100 TO 199	72	61	92	97	75	83	480
200 TO 399	80	77	159	221	123	126	786
400 OR MORE	77	52	89	96	80	95	489
ALL SIZES	303	233	411	484	321	370	2122
PERCENT							
6 TO 49	28.7%	7.4%	22.2%	15.7%	13.0%	13.0%	100.0%
50 TO 99	16.6%	13.5%	18.1%	20.5%	11.2%	20.1%	100.0%
100 TO 199	15.0%	12.7%	19.2%	20.2%	15.6%	17.3%	100.0%
200 TO 399	10.2%	9.8%	20.2%	28.1%	15.6%	16.0%	100.0%
400 OR MORE	15.7%	10.6%	18.2%	19.6%	16.4%	19.4%	100.0%
ALL SIZES	14.3%	11.0%	19.4%	22.8%	15.1%	17.4%	100.0%

SOURCE: 1984 Annual Survey of Hospitals, American Hospital Association, Copyright 1985.

TABLE 5
PATIENT MARGIN DISTRIBUTION BY HOSPITAL BED SIZE
RURAL HOSPITALS

	6%+ DEFICIT	3%-6% DEFICIT	0%-3% DEFICIT	0%-3% PROFIT	3%-6% PROFIT	6%+ PROFIT	TOTAL
NUMBER							
6 TO 49	287	80	91	87	49	56	650
50 TO 99	213	99	143	127	66	65	713
100 TO 199	70	61	100	114	88	59	492
200 TO 399	11	17	39	39	23	24	153
400 OR MORE	3	1	1	3	1	2	11
ALL SIZES	584	258	374	370	227	206	2019
PERCENT							
6 TO 49	44.2%	12.3%	14.0%	13.4%	7.5%	8.6%	100.0%
50 TO 99	29.9%	13.9%	20.1%	17.8%	9.3%	9.1%	100.0%
100 TO 199	14.2%	12.4%	20.3%	23.2%	17.9%	12.0%	100.0%
200 TO 399	7.2%	11.1%	25.5%	25.5%	15.0%	15.7%	100.0%
400 OR MORE	27.3%	9.1%	9.1%	27.3%	9.1%	18.2%	100.0%
ALL SIZES	28.9%	12.8%	18.5%	18.3%	11.2%	10.2%	100.0%

SOURCE: 1984 Annual Survey of Hospitals, American Hospital Association, Copyright 1985.

TABLE 6
PATIENT MARGIN DISTRIBUTION BY OWNERSHIP
ALL HOSPITALS

	6%+ DEFICIT	3%-6% DEFICIT	0%-3% DEFICIT	0%-3% PROFIT	3%-6% PROFIT	6%+ PROFIT	TOTAL
NUMBER							
PUBLIC	414	156	190	175	114	123	1172
VOLUNTARY	430	325	572	645	405	350	2727
INVESTOR	43	10	23	34	29	103	242
TOTAL	887	491	785	854	548	576	4141
PERCENT							
PUBLIC	35.3%	13.3%	16.2%	14.9%	9.7%	10.5%	100.0%
VOLUNTARY	15.8%	11.9%	21.0%	23.7%	14.9%	12.8%	100.0%
INVESTOR	17.8%	4.1%	9.5%	14.0%	12.0%	42.6%	100.0%
TOTAL	21.4%	11.9%	19.0%	20.6%	13.2%	13.9%	100.0%

SOURCE: 1984 Annual Survey of Hospitals, American Hospital Association, Copyright 1985.

TABLE 7
PATIENT MARGIN DISTRIBUTION BY REGION
ALL HOSPITALS

	6%+ DEFICIT	3%-6% DEFICIT	0%-3% DEFICIT	0%-3% PROFIT	3%-6% PROFIT	6%+ PROFIT	TOTAL
NUMBER							
I	30	29	81	57	13	14	224
II	117	95	129	114	29	5	489
III	91	62	91	108	92	120	564
IV	99	75	174	212	121	75	756
V	61	27	55	61	45	54	303
VI	199	89	103	113	73	75	652
VII	115	52	60	85	54	101	467
VIII	86	33	36	34	43	25	257
IX	89	29	56	70	78	107	429
ALL REGIONS	887	491	785	854	548	576	4141
PERCENT							
I	13.4%	12.9%	36.2%	25.4%	5.8%	6.3%	100.0%
II	23.9%	19.4%	26.4%	23.3%	5.9%	1.0%	100.0%
III	16.1%	11.0%	16.1%	19.1%	16.3%	21.3%	100.0%
IV	13.1%	9.9%	23.0%	28.0%	16.0%	9.9%	100.0%
V	20.1%	8.9%	18.2%	20.1%	14.9%	17.8%	100.0%
VI	30.5%	13.7%	15.8%	17.3%	11.2%	11.5%	100.0%
VII	24.6%	11.1%	12.8%	18.2%	11.6%	21.6%	100.0%
VIII	33.5%	12.8%	14.0%	13.2%	16.7%	9.7%	100.0%
IX	20.7%	6.8%	13.1%	16.3%	18.2%	24.9%	100.0%
ALL REGIONS	21.4%	11.9%	19.0%	20.6%	13.2%	13.9%	100.0%

SOURCE: 1984 Annual Survey of Hospitals, American Hospital Association, Copyright 1985.

TABLE 8
PATIENT MARGIN DISTRIBUTION BY REGION
URBAN HOSPITALS

	6%+ DEFICIT	3%-6% DEFICIT	0%-3% DEFICIT	0%-3% PROFIT	3%-6% PROFIT	6%+ PROFIT	TOTAL
NUMBER							
I	16	17	60	34	9	8	144
II	89	80	105	93	24	4	395
III	36	38	46	55	52	77	304
IV	45	36	90	135	82	47	435
V	12	9	16	27	17	25	106
VI	27	13	25	30	23	27	145
VII	21	19	20	47	32	73	212
VIII	12	4	6	13	20	15	70
IX	45	17	43	50	62	94	311
ALL REGIONS	303	233	411	484	321	370	2122
PERCENT							
I	11.1%	11.8%	41.7%	23.6%	6.3%	5.6%	100.0%
II	22.5%	20.3%	26.6%	23.5%	6.1%	1.0%	100.0%
III	11.8%	12.5%	15.1%	18.1%	17.1%	25.3%	100.0%
IV	10.3%	8.3%	20.7%	31.0%	18.9%	10.8%	100.0%
V	11.3%	8.5%	15.1%	25.5%	16.0%	23.6%	100.0%
VI	18.6%	9.0%	17.2%	20.7%	15.9%	18.6%	100.0%
VII	9.9%	9.0%	9.4%	22.2%	15.1%	34.4%	100.0%
VIII	17.1%	5.7%	8.6%	18.6%	28.6%	21.4%	100.0%
IX	14.5%	5.5%	13.8%	16.1%	19.9%	30.2%	100.0%
ALL REGIONS	14.3%	11.0%	19.4%	22.8%	15.1%	17.4%	100.0%

SOURCE: 1984 Annual Survey of Hospitals, American Hospital Association, Copyright 1985.

TABLE 9
PATIENT MARGIN DISTRIBUTION BY REGION
RURAL HOSPITALS

	6%+ DEFICIT	3%-6% DEFICIT	0%-3% DEFICIT	0%-3% PROFIT	3%-6% PROFIT	6%+ PROFIT	TOTAL
NUMBER							
I	14	12	21	23	4	6	80
II	28	15	24	21	5	1	94
III	55	24	45	53	40	43	260
IV	54	39	84	77	39	28	321
V	49	18	39	34	28	29	197
VI	172	76	78	83	50	48	507
VII	94	33	40	38	22	28	255
VIII	74	29	30	21	23	10	187
IX	44	12	13	20	16	13	118
ALL REGIONS	584	258	374	370	227	206	2019
PERCENT							
I	17.5%	15.0%	26.2%	28.7%	5.0%	7.5%	100.0%
II	29.8%	16.0%	25.5%	22.3%	5.3%	1.1%	100.0%
III	21.2%	9.2%	17.3%	20.4%	15.4%	16.5%	100.0%
IV	16.8%	12.1%	26.2%	24.0%	12.1%	8.7%	100.0%
V	24.9%	9.1%	19.8%	17.3%	14.2%	14.7%	100.0%
VI	33.9%	15.0%	15.4%	16.4%	9.9%	9.5%	100.0%
VII	36.9%	12.9%	15.7%	14.9%	8.6%	11.0%	100.0%
VIII	39.6%	15.5%	16.0%	11.2%	12.3%	5.3%	100.0%
IX	37.3%	10.2%	11.0%	16.9%	13.6%	11.0%	100.0%
ALL REGIONS	28.9%	12.8%	18.5%	18.3%	11.2%	10.2%	100.0%

SOURCE: 1984 Annual Survey of Hospitals, American Hospital Association, Copyright 1985.

STATEMENT OF STEPHEN H. LIPSON, PRESIDENT, DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. Lipson. My name is Stephen H. Lipson, and I am president of the District of Columbia Hospital Association, representing all hospitals located in the District of Columbia. I am pleased to have the opportunity to testify this morning regarding the effects of the prospective pricing system on central city hospitals.

The inspector general's recent report that hospitals had profits of more than 14 percent does not reflect the impact of PPS on the hospitals in the District of Columbia. I believe that our concern about this report is shared by many central city hospital leaders in large metropolitan areas throughout the Nation. That concern is one of loss. On average, hospitals in the District of Columbia received only 98 percent of their costs from the Medicare Program in 1984. That is a 2-percent loss, not the 14-percent profit the inspector general reported in his sample. And, these are costs, not charges.

In 1984, the District of Columbia Hospital Association conducted a study on how the prospective pricing system would affect urban hospitals. Our research was done in five major metropolitan areas: Chicago, Cleveland, Minneapolis-St. Paul, Philadelphia, and Washington, DC. We found some of the reasons why inner-city hospitals must spend more money to care for Medicare and other patients. We found important inequities in the PPS wage index and discrimination against disproportionate share hospitals.

The wage index is based on an entire metropolitan area. For Washington, DC, that includes counties as far away as Frederick in Maryland and Loudoun in Virginia. Hospitals in the far-out sections of the metropolitan area are going to benefit from a wage index average computed with the much higher central city wage level, and hospitals within the central city are going to lose with a wage index average computed with the much lower, far-out suburban wage level.

That is one of the reasons that PPS does not accurately reimburse hospitals in the central cities, and one of the reasons that DC hospitals are losing an average of $150 per Medicare patient.

The second reason is the disproportionate share problem. Hospitals in Washington, DC, serve an extraordinary number of low-income patients who require more costly and complex services than most other patients. These patients come to the hospitals in the District with multiple health problems beyond the reason for their hospitalization. Many suffer from poor nutrition. Many have untreated chronic diseases such as hypertension and diabetes. Many are alcoholics and drug abusers.

These patients require more care and more health education. They require more business office assistance to register for Medicaid benefits beyond Medicare. They often require longer hospital stays than Medicare patients in suburban or other areas because they have no source of adequate post-hospitalization care, and because nursing homes beds are in short supply.

Medicare patients are more costly for District of Columbia hospitals to treat, and in 1984 they caused an aggregate loss to this city's hospitals of some $5 million. These losses will grow substantially as PPS moves toward a national rate, and the impact of the losses becomes more dramatic every day.

Losses like these are aggravated by another problem for large city hospitals, that of financing massive amounts of care to the medically indigent. Hospitals in Washington, DC, provided $135 million in free care in 1984. That is a fact, and it is a good one. As a percent of all care provided by hospitals, the free care provided by the District's hospitals in 1984 was greater than that provided by hospitals in any of the 50 States.

If DC hospitals continue to provide $135 million in free care each year, and that amount is projected to increase in coming years, who will foot the bill? And if Medicare losses continue to grow, which they are also projected to do, who will foot the bill for the other $5 million loss this year and the additional losses next year as the transition to national rate under PPS continues?

Cost shifting used to be the answer, but cost containment forces from every direction—consumers, insurers, Federal, State, and local governments—are slashing the dollars available for cost shifting.

If unmanageable losses continue, hospitals will have no choice but to reduce services and limit access. The ultimate result will be the bankruptcy and closure of hospitals which serve the needy, hospitals which we can least afford to lose. And you know a closed hospital serves no one, not even paying patients.

The inspector general's report reflects only the average of the 892 hospitals in its survey. It does not illustrate the catastrophic effect that the Medicare Prospective Pricing System is having on central city hospitals, and will continue to have unless adjustments in payments are made to improve the fairness of PPS. At stake is the survival of many central city hospitals. Congressional attention to alleviate the plight of these hospitals and the millions of patients they serve deserves your priority. Thank you.

Senator DURENBERGER. Thank you very much. Mr. Kovener.

[The prepared statement of Mr. Lipson follows:]

STATEMENT OF THE
DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION

before the

SUBCOMMITTEE ON HEALTH
of the
COMMITTEE ON FINANCE
of the
UNITED STATES SENATE

on

LOSSES TO CENTRAL CITY HOSPITALS
FROM THE MEDICARE PROSPECTIVE PRICING SYSTEM

February 21, 1986

STEPHEN H. LIPSON
PRESIDENT
DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION

STATEMENT

My name is Stephen H. Lipson, and I am President of the District of Columbia Hospital Association. The Association represents all of the hospitals located in the District of Columbia. I am pleased to have the opportunity to testify before the Finance Committee's Subcommittee on Health regarding the effects of the Prospective Pricing System (PPS) on central city hospitals.

The Inspector General's recent report that hospitals had profits of more than 14 percent does not reflect the impact of PPS on the hospitals in the District of Columbia. I believe that our concern about this report is shared by many central city hospital leaders in large metropolitan areas throughout the nation.

That concern is one of loss. On average, hospitals in the District of Columbia received only 98% of their costs from the Medicare program in 1984. That is a two percent loss...not the 14 percent profit the Office of the Inspector General reported in his sample. And, these are costs, not charges.

In 1984, the District of Columbia Hospital Association conducted a study on how the Prospective Pricing System would affect urban hospitals. Our research was done in five major metropolitan areas: Chicago, Cleveland, Minneapolis-St. Paul, Philadelphia, and Washington, D.C. We found some of the reasons why inner city hospitals must spend more money to care for Medicare -- and other -- patients. We found important reasons that led to the 1985 Congressional actions on the PPS wage index and disproportionate share hospitals.

In your actions on those two issues, you recognized the plight of hospitals in central cities. You recognized that when PPS was developed, its wage index was based on an entire metropolitan area...for Washington, D.C. that includes counties as far away as Frederick in Maryland and Loudoun in Virginia. It is easy to see that those hospitals in the "far-out" sections of the metropolitan area are going to benefit from a wage index average computed with the much higher central city wage level, and that the hospitals within the central city are going to lose with a wage index average computed with the much lower far-out suburban wage level. (See Table 1)

That is, indeed, one of the reasons that PPS does not accurately reimburse hospitals in the central cities, and one of the reasons that D.C. hospitals are losing an average of $150 per Medicare patient.

The second reason is the disproportionate share problem. Hospitals in Washington, D.C. serve an extraordinary number of low income patients who require more costly and complex services than do most other patients. These patients come to the hospitals in the District with multiple health problems beyond the reason for their hospitalization. Many suffer from poor nutrition. Many have untreated chronic diseases such as hypertension and diabetes. Many are alcoholics and drug abusers.

These patients require more care and more health education. They require more business office assistance to qualify for Medicaid benefits beyond Medicare. They often require longer hospital stays than Medicare patients in suburban and other areas because they have no source of adequate post-hospitalization care, and because nursing home beds are in short supply.

Medicare patients are indeed more costly for District of Columbia hospitals to treat, and in 1984 they caused an aggregate loss to this City's hospitals of some $5 million dollars. The cost of care for Medicare patients in 1984 was $224 million; the hospitals were reimbursed only $219 million. These losses will grow substantially as PPS moves toward a national rate, and the impact of the losses becomes more dramatic every day. (See Table 2)

Losses like these are aggravated by another problem for large city hospitals — that of financing massive amounts of care to medically indigent people. Hospitals in Washington, D.C. provided $135 million in free care in 1984. That's a fact. And, it's a good one. As a percent of all care provided by hospitals, the free care provided by the District's hospitals in 1984 was greater than that provided by hospitals in any of the fifty states. (See Tables 3 and 4)

We know that hospitals' missions are to serve the people who live in their communities, and District hospitals stand out as distinguished institutions in this respect. Hospitals in central cities across the nation, like those in D.C., serve communities which have an unusually high number of uninsured, low income, and medically indigent people. I am proud that the hospitals in our nation's capital do serve indigent patients, fulfilling this very important mission. But I am also acutely aware of the consequences of what it costs hospitals to carry this burden.

If D.C. hospitals continue to provide $135 million in free care each year....and that amount is projected to increase in the coming years...who will foot the bill? And if Medicare losses continue to grow...which they are also projected to do...who will foot the bill for the $5 million loss this year, and the additional losses next year as the transition to national rates under PPS continues?

Cost shifting used to be the answer, but cost containment forces from every direction: consumers, insurers, federal, state, and local governments, are slashing the dollars available for cost shifting.

So here we are: District of Columbia hospitals serving 34,000 Medicare patients at a guaranteed loss, and thousands of indigent patients at an even greater loss...and the Inspector General has generalized that hospitals are profiting under PPS. Not in D.C., and not in most other central cities I suspect.

If unmanageable losses continue, hospitals will have no choice but to reduce services and limit access. The ultimate result will be the bankruptcy and closure of hospitals which serve the needy ...hospitals which we can least afford to lose. And you surely know, a closed hospital serves no one...not even paying patients.

The Inspector General's report reflects only the AVERAGE of the 892 hospitals it surveyed. It does not, however, illustrate the catastrophic effect that the Medicare Prospective Pricing System is having on central city hospitals, and will continue to have unless adjustments in payments are made to improve the fairness of PPS. At stake is the very survival of many central city hospitals which are the core of the nation's health delivery system. Congressional attention to alleviate the plight of these hospitals -- and the millions of hospitals they serve -- deserves your priority.

Thank you.

TABLE 1

CURRENT AND SEPARATE CORE/SUBURBAN WAGE INDEXES

City	Current Wage Index	Core/Suburban Wage Indexes		
		Core Jurisdiction*	Surrounding Suburban Jurisdictions*	Core to Suburban Relationship
Chicago	1.2196	1.2347	.9547	+29%
Cleveland	1.2028	1.2182	.9801	+24%
District of Columbia	1.1637	1.3286	1.0281	+29%
Minneapolis/ St. Paul	1.0271	1.0344	.9884	+ 5%
Philadelphia/ Camden	1.1760	1.2456	1.0807	+15%

* Based on unpublished employment and wage data obtained from the U.S. Bureau of Labor Statistics, Office of Employment and Unemployment Statistics, covering the same 1981 period used for HCFA's current published wage indexes.

TABLE 2

IMPACT OF THE MEDICARE PROSPECTIVE PAYMENT SYSTEM
ON CORE CITY AND SUBURBAN HOSPITALS

City	Cost Per Case Adjusted for Case Mix and Indirect Teaching			Gain (Loss) per Case Under Fourth Year PPS Conditions	
	City	Surrounding Suburbs	City to Suburb Relationship	City	Surrounding Suburbs
Chicago	$3,640	$3,087	18%	($1,611)	($570)
Cleveland	$3,026	$2,506	21%	($483)	$277
District of Columbia	$3,435	$2,632	31%	($1,546)	($36)
Minneapolis/ St. Paul	$2,699	$2,084	30%	($505)	$412
Philadelphia/ Camden	$2,875	$2,527	14%	($568)	$113
All Areas	$3,178	$2,695	18%	($976)	($108)

Source: John L. Ashby, "The Inequity of Medicare Prospective Payment in Large Urban Areas," DCHA publication, September 1984.

TABLE 3

TREND OF TOTAL COST OF UNCOMPENSATED CARE, OFFSETTING D.C. GOVERNMENT APPROPRIATION, AND GOVERNMENT REQUIRED UNCOMPENSATED CARE

	1983	1984		1985	
	Amount(000)	Amount(000)	% Change	Amount(000)	% Change
Cost of Uncompensated Care					
Inpatient Services	$74,402	$97,151	30.6%	$98,884	1.8%
Outpatient Services	$33,410	$38,077	14.0%	$37,370	-1.9%
TOTAL	$107,812	$135,228	25.4%	$136,254	0.8%
D.C. Government Appropriation to D.C. General Hospital*	$31,700	$35,100	10.7%	$37,150	5.8%
D.C. Government Appropriation as a Percent of Total Cost of Uncompensated Care	29.4%	26.0%	-11.7%	27.3%	5.0%
Total Cost of Uncompensated Care, Net of D.C. Government Appropriation	$76,112	$100,128	31.6%	$99,104	-1.0%
Total Hill-Burton or D.C. Certificate-of-Need (CON) Law Uncompensated Care Obligation	$8,577	$9,565	11.5%	$9,516	-0.5%
Total Hill-Burton or D.C. CON Law Uncompensated Care Obligation as a Percent of Total Cost of Uncompensated Care	8.0%	7.1%	-11.1%	7.0%	-1.3%

Source: DCHA Membership Survey, 1985

* Appropriaton net of cost of non-patient care services provided to other District agencies

TABLE 4

UNCOMPENSATED CARE CHARGES AS A PERCENT OF TOTAL CHARGES BY STATE AND THE DISTRICT OF COLUMBIA

State	Percent of Charges	State	Percent of Charges
1. District of Columbia	12.0%	27. Maryland	5.4%
2. Texas	10.1%	28. Louisiana	5.3%
3. Mississippi	9.7%	29. New York	4.9%
4. South Carolina	9.7%	30. Utah	4.8%
5. New Mexico	9.3%	31. Nevada	4.8%
6. Delaware	9.2%	32. Idaho	4.7%
7. Alabama	8.7%	33. Maine	4.6%
8. Tennessee	8.6%	34. Minnesota	4.4%
9. Virginia	7.7%	35. Illinois	4.3%
10. Georgia	7.4%	36. Vermont	4.3%
11. Massachusetts	7.3%	37. Alaska	4.2%
12. North Carolina	7.3%	38. Montana	4.2%
13. Wyoming	7.3%	39. Ohio	4.2%
14. Florida	7.0%	40. Washington	4.0%
15. Oklahoma	6.4%	41. Hawaii	3.8%
16. Oregon	6.4%	42. Kansas	3.8%
17. New Jersey	6.3%	43. Connecticut	3.7%
18. West Virginia	6.1%	44. California	3.6%
19. Indiana	6.0%	45. Nebraska	3.3%
20. Colorado	5.9%	46. Rhode Island	3.2%
21. New Hampshire	5.8%	47. South Dakota	3.2%
22. Arkansas	5.6%	48. Michigan	2.7%
23. Missouri	5.6%	49. Pennsylvania	2.6%
24. Iowa	5.5%	50. Wisconsin	2.5%
25. Arizona	5.4%	51. North Dakota	2.3%
26. Kentucky	5.4%	All States and D.C.	5.4%

Source: Special analysis prepared for DCHA by the Hospital Data Center, American Hospital Association.

STATEMENT OF RONALD R. KOVENER, VICE PRESIDENT, HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION, WASHINGTON, DC

Mr. KOVENER. Good morning. I am Ronald Kovener, vice president of the Healthcare Financial Management Association, a professional society of over 25,000 individuals who take care of the financial records of hospitals.

HFMA is pleased that the committee is giving attention to the fiscal health of our Nation's hospitals. It is essential that this be a financially healthy industry. Adequate financial resources are essential to assure access to all who need service and to achieve the continued progress in technology and quality that all of our citizens deserve.

The Federal Government's public policy role to assure access to high-quality health care must always be of higher magnitude of importance than its role as a purchaser of health care services for segments of the population.

The overall fiscal health of hospitals must be assessed from the perspective of profit, as well as cash flow, and must be evaluated in current terms and circumstances.

The move from the old cost-minus system was a good one. Improved profits in year one of the Prospective Price Setting System is acknowledged. These achievements benefited hospitals as well as the Federal Government. Profits are an important measure of fiscal health, but it is also important to consider cash flow—can hospitals pay their bills? The average time that elapses before current liabilities are paid has been steadily increasing. This trend evidences some liquidity problems.

A key reason for hospitals' liquidity problems is delays in getting paid—largely by Medicare. These problems are reflected in day revenue in accounts receivable that took a sharp turn up of almost 3 days in 1984 to a median of over 64.3 days. This increase results in large part from payment processing changes by Medicare such as: Change to the fee schedules for outpatient laboratory services, that caused extensive confusion, huge backlogs of bills, and multiple submissions of information; reduced intermediary funding that has resulted in their failure to verify data with resultant errors and processing delays; additional requirements for billing, including medical record coding and physician attestation and ever-changing intermediary instructions concerning bill information requirements; the Health Care Financing Administration's directives to intermediaries that they should process bills more slowly, and specific efforts to limit participation in the PIP program; PRO review of outlier cases that cause delay in processing; intermediary difficulties in assigning DRG's that require additional followup and verification by providers; and elimination of the Medicare cost report of eligibility that has caused confusion among intermediaries and beneficiaries and has slowed payment from insurers with secondary responsibility. These payment delay tactics are extremely inappropriate.

PPS rates were set on the basis of former Medicare cost with no factor for cash flow delay. Any business must include in its prices a recognition of the delay that occurs between spending cash and collecting cash. This is called working capital. Initially, Medicare gave great attention to minimizing cash flow considerations to avoid the necessity of recognizing working capital in rates. These past practices are part of the history that produced current PPS rates. Thus, changes in payment timing procedures exerts fiscal pressure that must be relieved or the rates paid must be increased to compensate for working capital.

Hospitals generally expected to be in a more favorable fiscal condition under PPS. Favorable results were expected as a result of prompt, decisive management action in response to the PPS major shift in incentives.

Profits were the incentive offered to change health care practices to the financial benefit of the Government. We see no harm in profit, and our data shows them to be modest.

The same anecdotal-type evidence that, in 1984, first disclosed favorable financial results points today to extremely bleak results. The slowdown in payment by Medicare coupled with a rate freeze, manipulation of rules to deny hospitals the fruits of their efforts—compounded by fiscal pressures from non-Medicare payers—requires prompt relief.

I would be pleased to answer questions.

[The prepared statement of Mr. Kovener follows:]

HFMA

HEALTHCARE
FINANCIAL
MANAGEMENT
ASSOCIATION

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STATEMENT OF THE
HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

About HFMA

The Healthcare Financial Management Association (HFMA) is a professional membership association composed of over 25,000 individuals in 74 chapters who share an interest in financial management of hospitals and other healthcare institutions.

HFMA's members include representatives from all major types of hospitals; urban and rural, large and small, investor-owned and tax-exempt, teaching and nonteaching, freestanding and multiple facility. In addition, our membership includes public accountants, financial consultants, and investment bankers, as well as representatives of Blue Cross, commercial insurors and others who pay for healthcare services. These are the individuals with primary responsibility for the fiscal health of hospitals and other institutional healthcare providers across the country.

HFMA operates a Financial Analysis Service (FAS) which provides each subscriber hospital with an annual report of its financial performance compared to other reports in our database. Financial performance is measured in terms of 29 ratios in five major categories: profitability, liquidity, capital structure, activity, and other.

Annually we publish the "Hospital Industry Analysis Report" based on our FAS data. Information from our FAS database is quoted in this testimony and selected pages of our most recent report are attached.

Introduction

HFMA is pleased that the committee is giving attention to the fiscal health of our nation's healthcare provider organizations. It is essential that this be a financially healthy industry. Adequate financial resources are essential to assure access to all who need service and to achieve the continued progress in technology and quality that all citizens deserve.

The federal government's public policy role to assure access to high quality healthcare services must always be of a higher magnitude of importance than its role as a purchaser of healthcare services for segments of the population. The relative importance of these roles is too often confused and purchasing decisions are made that interfere with the public policy role.

Today, I would like to help put the fiscal health of hospitals into perspective by discussing short-term, as well as long-term, measures of fiscal health and some of the difficulties and dangers of looking at parts of any organization rather than the organization as a whole. I will discuss:

- The change in Medicare payment arrangements and the benefits of PPS to hospitals and the government.
- The overall fiscal health of hospitals from the perspective of:
  - profit
  - cash flow.
- The difficulty of identifying cost of a segment of any organization and the shortcomings of the Medicare cost report as a basis for evaluating cost.
- The IG's memorandum on profit in the first year of PPS.

The Change in Medicare Payment Arrangements

From its inception, until the introduction of PPS, Medicare paid institutional healthcare providers on a cost basis. Over the years, Medicare's definition of "cost" became so distorted that the effect of the former system was the equivalent of Medicare saying, "Whatever you spend, Medicare will pay a portion of it. If you spend more, we'll pay more; if you spend less, we'll pay less -- but we'll never pay all the costs necessary to provide service to Medicare beneficiaries." This was a true "cost-minus" payment formula. No managerial initiatives to save money could offset the effect of the formula and avoid a Medicare payment shortfall.

Under the former arrangement, there was no alternative but for hospitals to charge payers other than Medicare more than their prorata share of cost to make up for the unavoidable shortfall. This payment deficiency has grown over the years.

The PPS system, on the other hand, allowed hospitals to institute operating economies to bring the cost of operations down to match the amounts that Medicare indicated it was going to pay. In the first year of PPS, many hospitals found it unnecessary to make price increases to other payers. However, I am not aware of hospitals reducing prices to other payers to reflect the fact that Medicare cost and revenues were in closer balance than had been true in previous years. It was widely recognized in the first year of PPS that many hospitals were doing well financially. However, this is not necessarily evidence that PPS rates were too high. It could be that payments by others than Medicare did not yet fully reflect the operating economies achieved by hospitals.

Furthermore, it was quite apparent from the beginning of PPS that rates could be established arbitrarily and the incentives inherent in the initial program would probably be short lived. Congress made this apparent almost immediately by reducing the portion of the original formula that recognized technological improvements. Since then the Administration has been even more arbitrary in overriding the initial provisions for adjusting rates in a manner that reflects inflationary pressures. Thus, hospitals were quite prudent in their decisions to keep rates charged to other payers at a level which might again be able to subsidize deficiencies in Medicare payments.

The evaluation of any financial benefit achieved by hospitals in the first year of PPS must be balanced against recognition of the $3 billion savings that accrued to the federal government. Original PPS legislation specified that hospitals would be paid "no more than, nor less than" would have been spent under the previous system. Actual spending, however, was at least $3 billion less than this budget neutrality target. Medicare program savings were very substantial.

Hospitals responded to new Medicare incentives very promptly; to the benefit of both the hospitals and the Medicare program. We see no sin in hospitals making a modest operating margin, or "profit," even when dealing with the government as the purchaser. After the fact criticism of the hospital industry for achieving the objectives that were established undermines the opportunity for constructive relationships in the future.

Fiscal Health

Two important measures of fiscal health must be considered in evaluating the overall results of operations of hospitals -- profit and cash flow. Current experience, as well as 1984 data must also be considered.

Profit

Data compiled by the American Hospital Association is generally acknowledged to be the most complete industry data available and includes an industry-wide data compilation system, as well as current data compiled from a sample of hospitals selected to yield statistically valid results.

HFMA also offers its Financial Analysis Service (FAS), an industry data service available on a subscription basis.* 1984 information about 1,252 hospitals is in the FAS database on February 12. This data shows that in 1984 the median hospital had an operating margin of 3.1 percent (minus 1/10 percent if adjusted for price level depreciation) and a return on equity of 10.5 percent. The operating margin is the excess of revenue over expenses from operations -- primarily services to patients. The return on equity is the amount earned from all activities, including contributions and earnings on real estate or other nonpatient service activities.

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*HFMA's Financial Analysis Services (FAS) is based on audited financial reports (not Medicare cost reports or coded data provided by hospitals). As a result, the data is extremely reliable. All coding is done centrally to improve uniformity. Comparability and consistency is much better than with unaudited data. A total of 1,144 hospitals are included in HFMA's "Hospital Industry Analysis Report" (derived from FAS data). Selected pages of our 1984 report are attached. The data may not be representative of the hospital industry as a whole and we believe subscribers tend to be more financially healthy than average. In total, data from 6,796 hospital years is included in the most recent published five year report. Since FAS is based on audit reports of fiscal years that ended in 1984, only about a third of the reports are for the first year of PPS.

The median operating margin of 3.1 percent is up from 2.1 percent in 1983. The price level adjusted operating margin improved from minus 1 percent to minus 1/10 percent. A quarter of all subscriber hospitals had an operating margin of 7/10 percent or less, including many with an operating loss. On a price level adjusted basis, even the median hospital is operating at a loss. There is significant variation in operating margin by region, with the Northeast having the lowest with a median of only 1 percent. Only 3 percent of the IG's sample was from this major region that traditionally has the lowest median operating ratio.

The median return on equity of 10.5 percent in 1984 was an increase from 8.9 percent in 1983. This continues a general upward trend in this ratio as measured by HFMA's service since 1978, reflecting the diversification many healthcare organizations have pursued. This ratio also has significant regional differences.

Standard & Poor's bond ratings correlate with the ratios calculated by FAS -- and consideration of these ratios is a determinant of the rates. In 1984, a hospital with the median operating margin was slightly below the average of hospitals with an A- rating. Hospitals with an A+ rating had an operating margin of 4.6 percent. Similarly, the median return on equity was below the S&P A- rating. Hospitals with an A+ rating had a return on equity of 13 percent. These results demonstrate that hospital profitability is relatively low in comparison to other businesses.

Cash Flow

Profits are an important measure of fiscal health, but it is also important to consider cash flow -- can hospitals pay their bills? HFMA's FAS shows that the average time that elapses before current liabilities are paid reached over 54 days in 1984 with a quarter of subscriber hospitals taking 67 days or longer. This lag time has been steadily increasing since 1978 and increased by a larger than normal percent in 1984. This trend evidences some liquidity problems.

A key reason for hospitals' liquidity problems is delays in getting paid -- largely by Medicare. These problems are reflected in days revenue in accounts receivable that took a sharp turn up of almost 3 days in 1984 to a median of over 64.3 days.

This increase results in large part from payment processing changes by Medicare such as:

- Change to fee schedules for outpatient laboratory services that caused extensive confusion, huge backlogs of bills, and multiple submissions of information.
- Reduced intermediary funding that has resulted in their failure to verify data with resultant errors and processing delays.
- Additional requirements for billing, including medical record coding and physician attestation and ever-changing intermediary instructions concerning bill information requirements.
- Strong indications to intermediaries from the Health Care Financing Administration that they should process bills more slowly.
- PRO review of outlier cases that causes delay in processing.

- Intermediary difficulties in assigning DRGs that require additional follow-up and verification by providers.
- Elimination of the Medicare Report of Eligibility that has caused confusion among intermediaries and beneficiaries and has slowed payment from insurors with secondary responsibility.

These payment delay tactics are extremely inappropriate. PPS rates were set on the basis of former Medicare cost with no factor for cash flow delay. Any business must include in its prices a recognition of the delay that occurs between spending cash and collecting cash. This is called working capital. Initially, Medicare gave great attention to minimizing cash flow considerations to avoid the necessity of recognizing working capital in rates. These past practices are part of the history that produced current PPS rates. Thus, changes in payment timing produce fiscal pressure that must be relieved or the rates paid must be increased to compensate for working capital.

Current Experience

Hospitals generally expected to be in more desirable financial condition under PPS than under previous Medicare payment arrangements. Favorable results were expected as a result of prompt, decisive management action in response to the PPS major shift in incentives. At the same time some hospitals were taking comfort in some desirable financial results, they recognized that harder times were on the horizon. These harder times have occurred with even more severity than anticipated. The statutory provision initially made for new technology was quickly cut by Congress from 1 percent to .25 percent. Other changes were made in payment arrangements and now rates have been frozen, so there is no recognition of the higher cost of goods and services hospitals must pay to serve Medicare and other patients. These cuts in Medicare payments have been paralleled by new pressures from employers through HMO, PPO, and other arrangements. Cuts in occupancy require that fixed cost be spread over fewer patients, thus raising the cost of each service. Also, less complex cases are now more commonly served in nonhospital settings, leaving only the more complex and costly patients in hospitals. The combined influence of more restrictive payment arrangements, the Medicare payment freeze, reduced occupancy and increased case complexity have dire implications to the future quality and availability of healthcare services.

Cost Accounting

Cost accounting is primarily a management tool to facilitate management decisions. Cost information is used for determining prices, but cost is only one of many factors considered by a business in making pricing decisions. Cost accounting can identify, with considerable precision, the average direct cost of a unit of activity. Assignment of indirect cost, however, can be done in a host of different ways -- all of which are acceptable for the various purposes for which cost data is compiled. Marginal cost accounting procedures may be used to determine cost if one more unit is produced or one fewer unit. Standard cost accounting methods are most appropriate for evaluating productivity and variable cost accounting (which separates fixed from semi-variable and variable cost) is used to evaluate operating results in the event of changing volume. The government often makes judgements based on a misunderstanding of cost accounting. Too often it is assumed that there is a single correct answer about cost. Cost accounting is not precise in that sense. It is extremely difficult to measure with precision the cost of a single service, a single patient, or even a group of patients. It is generally recognized that Medicare patients require more extensive and expensive service than other patients with the same diagnosis or condition. Measuring these differences in cost with precision is difficult, but the PPS rates were intended to recognize the extra service to Medicare patients.

While the Medicare cost report is a rough approximation of cost attributable to Medicare patients, it is deficient in several very important respects. For example, courts are in almost universal agreement that the Medicare cost report yields a distorted result in the way it handles labor room days and malpractice insurance. Medicare's share of the cost of uncompensated services is ignored as is the cost of ownership.

In summary, cost accounting is a management tool that can yield a variety of answers from the same set of data -- each possibly appropriate to its intended use, but the results are also subject to misunderstanding. The Medicare cost report is not a particularly meaningful measure of the cost of serving Medicare patients. Cost as measured in the old cost-based Medicare system is clearly an invalid basis of evaluating the new incentives of PPS.

THE INSPECTOR GENERAL'S MEMORANDUM

The Inspector General's memorandum must be evaluated in terms of:

- the data on which it was based
- the validity of the sample
- its relevance to today's circumstances.

The IG compared PPS revenue with cost as calculated on the Medicare cost report. In addition to the deficiencies noted above, the IG's report ignores the cost of ownership while including the revenue factor Congress provided to compensate for this cost. All the Medicare disputes are ignored. The handling of deductible and coinsurance is unclear. In short, cost accounting in general, and the Medicare cost report specifically, does not lend itself to drawing the conclusions included in the IG's report. Furthermore, the overall financial results for hospitals do not evidence any windfall financial benefit.

The first PPS year for each hospital is its fiscal year beginning after October 1, 1983. A fiscal year starting as late as September 1984 and extending to September 1985 could, therefore, be classified as the first PPS year. HFMA's "A Survey of Financial Reporting and Accounting Developments in the Hospital Industry*" shows that 49 percent of hospitals have fiscal years that end on June 30, 19 percent on September 30, 15 percent on December 31, and 17 percent on other dates.

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*HFMA and Price Waterhouse, "A Survey of Financial Reporting and Accounting Developments in the Hospital Industry," February 1984, A hospital's cost report is due 90 days after the end of the hospital's fiscal year. For the first year of PPS (and in all recent years), no cost reports were due until at least 60 days after new cost report forms were available. Thus, the earliest reports for year one of PPS were not filed until about March of 1985. The time of the IG's analysis is not clear, but it must have been September 1985 or earlier. Considering delays in availability of forms and fiscal year ends, in September 1985, it is reasonable to assume that only about one-third of the cost reports for the first year of PPS were available. Thus, the IG's analysis, based on cost reports available at that time, would be based on a very limited and not necessarily representative sample.

Even more importantly however, is the question of the relevance of the type of analysis done by the IG to current circumstances. PPS rates are not intended to be related to cost and are intended to offer incentives to operate hospitals at lower costs. Savings to the government have been very substantial -- much greater and quicker even than initial legislation contemplated.

We are now in year three of PPS and changes since year one have been dramatic. Rates have not kept pace with inflation and are currently frozen. No business can operate, even in a period of modest inflation, with no rate increase and remain fiscally sound. It is necessary to raise rates to other payers or cut services to Medicare beneficiaries. Both are doubtless occurring. Furthermore, rates have been manipulated to deny to hospitals any reward for the cost saving initiatives instituted or to pay for the more severely-ill patients now being served. These practices have dire implications to the future.

Conclusion

Attention to the fiscal health of hospitals is timely. The first year of PPS demonstrated that with new incentives, hospitals could save money. Both hospitals and the government benefited. Industry data shows, as expected, improvements in profitability at that time. The same anecdotal-type evidence that in 1984 first disclosed favorable financial results point to extremely bleak results today. The slow down in payment by Medicare coupled with a rate freeze, manipulation of rules to deny hospitals the fruits of their efforts (compounded by fiscal pressures from non-Medicare payers) require prompt relief. The IG's memorandum hardly deserves mention due to questionable methods, poor sample selection, and subsequent events. I will be pleased to answer questions.

Appendix to
HFMA Testimony

HOSPITAL INDUSTRY ANALYSIS REPORT
1980-1984*

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The Ohio State University

Individual Financial Ratio Indicators

Deductible ratio
Markup ratio
Operating margin ratio
Nonoperating revenue ratio
Reported income index ratio
Return on total assets ratio
Return on equity ratio
Current ratio
Quick ratio
Acid test ratio
Days in patient accounts receivable ratio
Average payment period ratio
Days cash on hand ratio
Equity financing ratio
Cash flow to total debt ratio
Long-term debt to equity ratio
Fixed asset financing ratio
Times interest earned ratio
Debt service coverage ratio
Total asset turnover ratio
Fixed asset turnovr ratio
Current asset turnover ratio
Inventory ratio
Average age of plant ratio
Price-level adjusted depreciation ratio
Operating margin (price-level adjusted) ratio
Restricted equity ratio
Viability index ratio
Replacement viability ratio

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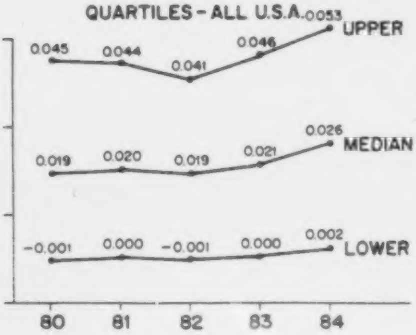
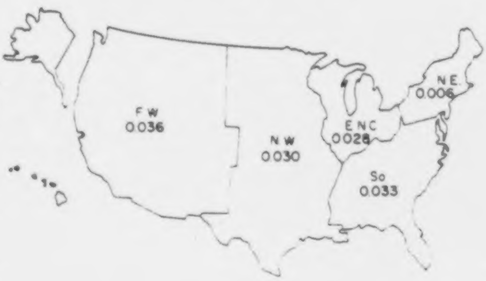
Relevant pages of ratios designated in bold above are attached.

OPERATING MARGIN RATIO

QUARTILES - ALL U.S.A.



1984 - REGIONAL MEDIANS



Discussion:

- The operating margin ratio defines the proportion of operating revenue (net of deductions) retained as income. This ratio is a function of the markup ratio and the deductible ratio.

- Operating margins increased in both 1983 and 1984 for the first time since 1977 when data was first accumulated. The 1984 national median value of 2.6 percent was 24 percent above the comparable 1983 value of 2.1 percent.

- There is an extremely important regional effect on operating margins. Northeast hospitals have consistently reported operating margins significantly below other regions. The 1984 median Northeast value of 0.006 was only 21 percent of the East North Central regional value of 0.028, which was the next lowest. Operating margin increases occurred in all regions during 1984, however, increases in the Far West and Southern regions were especially large.

- Larger hospitals have higher operating margins than smaller hospitals. Hospitals with more than 400 beds had a median operating margin of 3.2% in 1984 compared to .9% for those hospitals under 100 beds.

- Rural hospitals have consistently had much lower operating margins than urban hospitals. The 1984 median value for rural hospitals was 1.95 percent compared to 2.80 percent for urban hospitals. These differences may increase more as the PPS payment provisions for urban and rural hospital are phased in over the next several years.

- Cost control will become increasingly important as the percentage of cost payers diminishes. Reductions in costs will increase markup ratios, but they will not increase deductible ratios as they have in the past. The net effect of cost reductions will be increased operating margins.

- Operating margins have a pervasive effect on many other ratios. The operating margin ratio is positively correlated with the cash flow to total debt, times interest earned, return on total assets, return on equity and the operating margin (price-level adjusted) ratios.

1980 - 1984 COMPARATIVE VALUES FOR OPERATING MARGIN RATIO

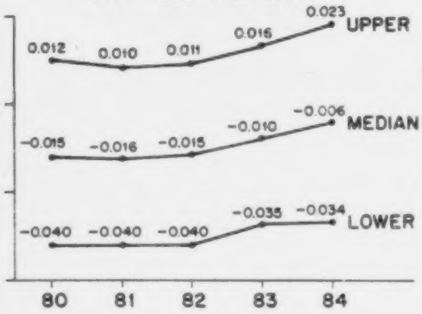
		1980	1981	1982	1983	1984
NATIONAL	**LOWER**	-0.001	0.000	-0.001	0.000	0.002
	MEDIAN	0.019	0.020	0.019	0.021	0.026
	UPPER	0.045	0.044	0.041	0.046	0.053
REGIONAL						
N.E.	**LOWER**	-0.015	-0.014	-0.015	-0.011	-0.012
	MEDIAN	0.004	0.004	0.002	0.005	0.006
	UPPER	0.019	0.020	0.020	0.021	0.023
E.N.C.	**LOWER**	0.003	0.003	0.003	0.003	0.005
	MEDIAN	0.021	0.021	0.019	0.021	0.028
	UPPER	0.040	0.039	0.036	0.042	0.051
SO.	**LOWER**	-0.006	-0.005	0.000	[illegible]	0.007
	MEDIAN	0.022	0.018	[illegible]	0.026	0.033
	UPPER	0.047	0.049	[illegible]	0.053	[illegible]
N.W.	**LOWER**	0.008	0.004	[illegible]	[illegible]	0.008
	MEDIAN	[illegible]	0.028	[illegible]	[illegible]	0.030
	UPPER	[illegible]	0.052	[illegible]	[illegible]	0.068
F.W.	**LOWER**	0.006	0.009	[illegible]	0.010	0.011
	MEDIAN	[illegible]	0.034	0.031	0.032	0.036
	UPPER	[illegible]	0.058	0.053	0.058	0.062
BEDSIZE						
[illegible]	**LOWER**	-0.026	-0.024	-0.028	-0.022	[illegible]
	MEDIAN	0.007	0.008	0.004	0.006	0.009
	UPPER	0.034	[illegible]	0.031	0.033	0.036
100-199	**LOWER**	[illegible]	-0.001	-0.005	0.001	0.000
	MEDIAN	0.021	0.019	0.019	0.020	0.022
	UPPER	0.045	[illegible]	0.040	0.044	[illegible]
200-299	**LOWER**	[illegible]	0.001	0.002	[illegible]	0.006
	MEDIAN	0.021	0.020	0.019	[illegible]	0.029
	UPPER	0.047	0.045	0.043	[illegible]	0.053
300-399	**LOWER**	0.007	0.006	0.005	[illegible]	[illegible]
	MEDIAN	0.023	0.025	0.025	0.028	0.032
	UPPER	0.046	0.049	0.044	0.047	0.056
>=400	**LOWER**	[illegible]	0.004	0.003	0.006	0.010
	MEDIAN	0.021	0.024	0.022	0.027	0.032
	UPPER	0.045	0.047	0.045	0.052	0.064

		1980	1981	1982	1983	1984
REGIONAL/BEDSIZE						
N.E./<100	**MEDIAN**	-0.004	[illegible]	-0.004	-0.005	-0.007
N.E./100-199	**MEDIAN**	0.003	0.004	0.003	0.007	0.007
N.E./200-299	**MEDIAN**	0.003	[illegible]	0.003	0.005	0.006
N.E./300-399	**MEDIAN**	0.008	0.010	0.007	0.008	0.011
N.E./>=400	**MEDIAN**	0.004	0.005	0.003	0.007	0.007
E.N.C./<100	**MEDIAN**	0.013	0.015	0.005	[illegible]	0.020
E.N.C./100-199	**MEDIAN**	0.021	0.015	0.018	0.016	0.023
E.N.C./200-299	**MEDIAN**	0.024	0.020	0.018	0.018	0.035
E.N.C./300-399	**MEDIAN**	0.019	[illegible]	[illegible]	0.025	0.033
E.N.C./>=400	**MEDIAN**	0.021	0.025	0.024	0.024	0.029
SO./<100	**MEDIAN**	-0.008	-0.001	0.007	0.004	0.012
SO./100-199	**MEDIAN**	0.020	0.015	[illegible]	0.020	0.027
SO./200-299	**MEDIAN**	0.023	0.019	0.031	0.030	0.032
SO./300-399	**MEDIAN**	[illegible]	[illegible]	0.031	[illegible]	0.035
SO./>=400	**MEDIAN**	0.033	0.027	0.033	0.036	0.051
N.W./<100	**MEDIAN**	0.013	0.004	0.000	0.009	0.009
N.W./100-199	**MEDIAN**	0.030	0.028	0.020	0.028	0.024
N.W./200-299	**MEDIAN**	0.041	0.034	0.043	0.048	0.039
N.W./300-399	**MEDIAN**	0.046	0.042	0.040	0.035	0.039
N.W./>=400	**MEDIAN**	0.042	0.041	0.040	0.052	0.065
F.W./<100	**MEDIAN**	0.018	0.024	0.022	0.017	0.019
F.W./100-199	**MEDIAN**	0.031	0.037	0.036	0.035	0.036
F.W./200-299	**MEDIAN**	0.043	0.041	0.032	0.037	0.047
F.W./300-399	**MEDIAN**	0.028	0.035	0.036	0.036	0.053
F.W./>=400	**MEDIAN**	0.029	0.035	0.028	0.032	0.036

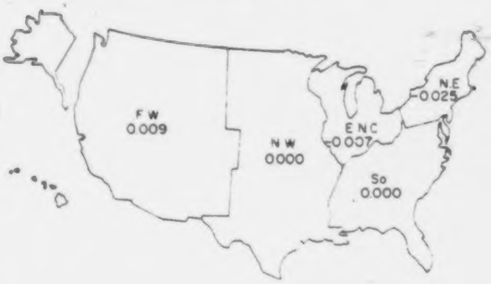
FAS

OPERATING MARGIN (PRICE-LEVEL ADJUSTED) RATIO

QUARTILES - ALL U.S.A.



1984 - REGIONAL MEDIANS



Discussion:

- The operating margin (price-level adjusted) ratio is identical to the operating margin ratio except that it substitutes price-level depreciation for unadjusted historical cost depreciation expense. While not totally accurate, this measure of operating profitability attempts to reflect the replacement cost of fixed assets in the calculation of the operating margin. Values for this ratio that are below 0 imply that the organization is not currently earning enough operating income to provide funds for the eventual replacement of its fixed assets.

- The deterioration in the operating margin (price-level adjusted) ratio was reversed in 1982. Increases in 1982, 1983 and 1984 have taken place. The reasons for these increases are related to a dramatic reduction in inflation and an improvement in unadjusted operating margins. It is important to note however that fewer than 50 percent of the hospitals have positive operating margin (price-level adjusted) ratios. This implies a failure to recover replacement costs from operating profits.

- There does appear to be significant regional differences in values for the operating margin (price-level adjusted) ratio. Northeastern hospitals have values that are significantly below other regions. This supports and amplifies the earlier conclusions with respect to the need for operating profitability improvement in the Northeast.

- Rural hospitals have significantly lower operating margin (price level adjusted) ratios than urban hospitals. This is due to two factors. First, unadjusted operating margins are lower in rural hospitals. Second, replacement cost depreciation is relatively larger in rural hospitals because of their older plant.

- The operating margin (price-level adjusted) ratio is positively correlated with the operating margin ratio.

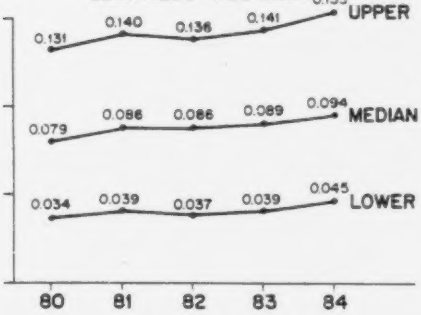
1980 - 1984 COMPARATIVE VALUES FOR OPERATING MARGIN (PRICE LEVEL ADJUSTED) RATIO

		1980	1981	1982	1983	1984
NATIONAL	**LOWER**	-0.040	-0.040	-0.040	-0.035	-0.034
	MEDIAN	-0.015	-0.016	-0.015	-0.017	-0.006
	UPPER	0.012	0.010	0.011	0.016	0.023
REGIONAL						
N.E.	**LOWER**	-0.049	-0.051	-0.052	-0.048	-0.047
	MEDIAN	-0.032	-0.031	-0.031	-0.027	-0.025
	UPPER	-0.014	-0.015	-0.011	-0.010	-0.005
E.N.C.	**LOWER**	-0.037	-0.034	-0.034	-0.034	-0.031
	MEDIAN	-0.014	-0.015	-0.016	-0.013	-0.007
	UPPER	0.004	0.003	0.002	0.009	0.020
SO	**LOWER**	-0.041	-0.044	-0.038	[illegible]	-0.025
	MEDIAN	-0.011	-0.015	[illegible]	-0.003	0.000
	UPPER	0.015	0.015	[illegible]	0.026	[illegible]
N.W.	**LOWER**	-0.032	-0.036	[illegible]	[illegible]	-0.035
	MEDIAN	[illegible]	-0.008	[illegible]	[illegible]	0.000
	UPPER	[illegible]	0.021	[illegible]	[illegible]	0.033
F.W.	**LOWER**	-0.028	[illegible]	[illegible]	[illegible]	[illegible]
	MEDIAN	[illegible]	0.004	[illegible]	[illegible]	0.009
	UPPER	[illegible]	0.032	[illegible]	[illegible]	0.035
BEDSIZE						
<100	**LOWER**	-0.067	-0.073	-0.074	-0.068	-0.072
	MEDIAN	-0.029	-0.028	-0.031	-0.029	[illegible]
	UPPER	0.003	[illegible]	0.000	0.002	[illegible]
100-199	**LOWER**	[illegible]	-0.043	[illegible]	[illegible]	-0.036
	MEDIAN	[illegible]	-0.015	[illegible]	[illegible]	-0.009
	UPPER	0.014	[illegible]	0.010	[illegible]	[illegible]
200-299	**LOWER**	[illegible]	-0.038	-0.032	[illegible]	[illegible]
	MEDIAN	[illegible]	-0.015	-0.013	[illegible]	[illegible]
	UPPER	0.012	0.010	0.013	[illegible]	[illegible]
300-399	**LOWER**	-0.030	-0.029	-0.032	[illegible]	[illegible]
	MEDIAN	-0.015	-0.012	-0.009	[illegible]	[illegible]
	UPPER	[illegible]	0.014	0.012	[illegible]	0.027
>=400	**LOWER**	[illegible]	-0.033	-0.033	-0.024	-0.023
	MEDIAN	[illegible]	-0.011	-0.009	-0.004	0.001
	UPPER	[illegible]	0.015	0.015	0.022	0.034

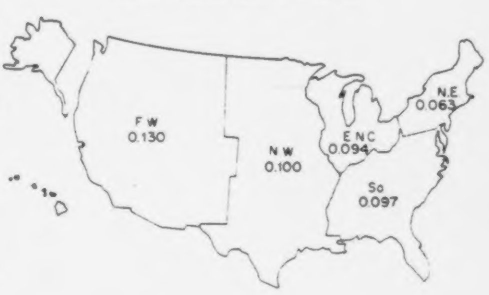
		1980	1981	1982	1983	1984
REGIONAL/BEDSIZE						
N.E./<100	**MEDIAN**	-0.041	[illegible]	-0.040	-0.037	-0.041
N.E./100-199	**MEDIAN**	-0.031	-0.031	[illegible]	-0.026	-0.024
N.E./200-299	**MEDIAN**	[illegible]	[illegible]	-0.030	-0.025	-0.024
N.E./300-399	**MEDIAN**	-0.027	-0.026	[illegible]	-0.025	-0.022
N.E./>=400	**MEDIAN**	-0.032	-0.031	-0.032	-0.023	-0.022
E.N.C./<100	**MEDIAN**	-0.021	[illegible]	-0.032	[illegible]	-0.019
E.N.C./100-199	**MEDIAN**	[illegible]	-0.019	-0.016	[illegible]	-0.014
E.N.C./200-299	**MEDIAN**	-0.011	-0.016	-0.018	-0.012	[illegible]
E.N.C./300-399	**MEDIAN**	-0.018	[illegible]	[illegible]	-0.010	[illegible]
E.N.C./>=400	**MEDIAN**	[illegible]	-0.011	-0.011	-0.008	[illegible]
SO./<100	**MEDIAN**	-0.038	-0.036	-0.020	-0.028	[illegible]
SO./100-199	**MEDIAN**	-0.011	-0.017	[illegible]	-0.011	0.001
SO./200-299	**MEDIAN**	[illegible]	-0.011	[illegible]	[illegible]	0.000
SO./300-399	**MEDIAN**	[illegible]	[illegible]	-0.004	[illegible]	0.002
SO./>=400	**MEDIAN**	0.000	-0.005	[illegible]	0.008	0.016
N.W./<100	**MEDIAN**	[illegible]	[illegible]	-0.047	-0.040	-0.038
N.W./100-199	**MEDIAN**	-0.014	-0.004	-0.011	0.002	-0.002
N.W./200-299	**MEDIAN**	0.008	0.005	0.011	0.014	0.010
N.W./300-399	**MEDIAN**	0.007	0.007	0.003	0.000	0.006
N.W./>=400	**MEDIAN**	0.006	0.007	0.008	0.019	0.030
F.W./<100	**MEDIAN**	-0.015	-0.002	-0.009	-0.009	-0.007
F.W./100-199	**MEDIAN**	0.001	0.006	0.009	0.009	0.011
F.W./200-299	**MEDIAN**	0.010	0.010	0.006	0.015	0.020
F.W./300-399	**MEDIAN**	0.000	0.001	0.005	0.008	0.023
F.W./>=400	**MEDIAN**	-0.002	0.006	0.000	0.007	0.008

RETURN ON EQUITY RATIO

QUARTILES - ALL U.S.A.



1984 - REGIONAL MEDIANS



Discussion:

- The return on equity ratio defines the amount of net income earned per dollar of unrestricted equity investment or fund balance. It is a function of four ratios:

$$\text{Return on Equity Ratio} = \frac{\text{Total Asset Turnover Ratio} \times \text{Operating Margin Ratio}}{(1.0 - \text{Nonoperating Revenue Ratio}) \times \text{Equity Financing Ratio}}$$

- Return on equity increased in 1984 to 0.094. The reason for this increase is directly tied to increasing operating margins.
- There is again a strong regional bias. Northeast hospitals exhibit far lower return on equity ratios than other regions. This is a direct result of their poor operating profit position.
- Rural hospitals have had consistently lower return on equity values than urban hospitals. This is a direct result of lower operating margins and also less financial leverage.
- Return on equity is positively correlated with operating margin and return on total assets. However, there is no significant correlation with equity financing or long-term debt to equity. In other words, the percentage of debt financing (or leverage) does not appear to affect return on equity nearly as much as profitability.

1980 - 1984 COMPARATIVE VALUES FOR RETURN ON EQUITY RATIO

		1980	1981	1982	1983	1984
NATIONAL	**LOWER**	0.034	0.039	0.037	0.039	0.045
	MEDIAN	0.079	0.086	0.086	0.089	0.094
	UPPER	0.131	0.140	0.136	0.141	0.153
REGIONAL						
N.E.	**LOWER**	0.013	0.014	0.012	0.016	0.015
	MEDIAN	0.051	0.058	0.058	0.061	0.063
	UPPER	0.089	0.098	0.105	0.107	0.110
E.N.C.	**LOWER**	0.037	0.046	0.041	0.040	0.048
	MEDIAN	0.076	0.086	0.081	0.085	0.094
	UPPER	0.116	0.126	0.122	0.123	0.144
SO	**LOWER**	0.034	0.025	0.041	[illegible]	0.050
	MEDIAN	0.080	0.083	[illegible]	0.086	0.097
	UPPER	0.122	0.137	[illegible]	0.143	[illegible]
N.W.	**LOWER**	0.046	0.047	0.046	[illegible]	0.051
	MEDIAN	[illegible]	0.097	0.090	[illegible]	0.100
	UPPER	[illegible]	0.147	[illegible]	[illegible]	[illegible]
F.W.	**LOWER**	0.061	[illegible]	[illegible]	[illegible]	0.075
	MEDIAN	[illegible]	0.132	[illegible]	[illegible]	0.130
	UPPER	[illegible]	0.178	[illegible]	[illegible]	0.191
BEDSIZE						
<100	**LOWER**	0.000	0.006	0.001	0.012	0.012
	MEDIAN	0.056	0.061	0.062	0.064	0.067
	UPPER	0.122	[illegible]	0.122	0.129	[illegible]
100-199	**LOWER**	[illegible]	0.036	[illegible]	0.037	0.042
	MEDIAN	[illegible]	0.084	[illegible]	[illegible]	0.094
	UPPER	0.143	[illegible]	0.133	[illegible]	[illegible]
200-299	**LOWER**	[illegible]	0.054	0.050	[illegible]	[illegible]
	MEDIAN	[illegible]	0.094	0.095	[illegible]	[illegible]
	UPPER	0.130	0.138	0.140	[illegible]	[illegible]
300-399	**LOWER**	0.043	0.047	0.050	[illegible]	[illegible]
	MEDIAN	0.083	0.096	0.093	[illegible]	0.099
	UPPER	[illegible]	0.143	0.147	[illegible]	0.164
=400	**LOWER**	[illegible]	0.047	0.047	0.057	0.059
	MEDIAN	[illegible]	0.094	0.090	0.102	0.110
	UPPER	0.124	0.140	0.136	0.144	0.163

REGIONAL/BEDSIZE		1980	1981	1982	1983	1984
N.E./<100	**MEDIAN**	0.021	[illegible]	0.013	0.033	0.021
N.E./100-199	**MEDIAN**	0.055	0.059	0.057	0.060	0.061
N.E./200-299	**MEDIAN**	[illegible]	[illegible]	0.061	0.063	0.064
N.E./300-399	**MEDIAN**	0.053	0.048	0.066	0.063	0.068
N.E./>=400	**MEDIAN**	0.052	0.060	0.059	0.061	0.064
E.N.C./<100	**MEDIAN**	[illegible]	[illegible]	0.043	[illegible]	0.065
E.N.C./100-199	**MEDIAN**	[illegible]	0.072	0.076	[illegible]	0.078
E.N.C./200-299	**MEDIAN**	0.088	0.087	0.081	0.081	[illegible]
E.N.C./300-399	**MEDIAN**	0.080	[illegible]	[illegible]	0.091	[illegible]
E.N.C./>=400	**MEDIAN**	[illegible]	0.098	0.092	0.096	[illegible]
SO./<100	**MEDIAN**	0.023	0.033	0.076	0.055	[illegible]
SO./100-199	**MEDIAN**	0.069	0.058	[illegible]	0.071	0.094
SO./200-299	**MEDIAN**	[illegible]	0.095	[illegible]	[illegible]	0.092
SO./300-399	**MEDIAN**	[illegible]	[illegible]	0.086	[illegible]	0.107
SO./>=400	**MEDIAN**	0.086	0.080	[illegible]	0.104	0.116
N.W./<100	**MEDIAN**	[illegible]	[illegible]	0.046	0.052	0.053
N.W./100-199	**MEDIAN**	0.093	0.103	0.091	0.100	0.101
N.W./200-299	**MEDIAN**	0.108	0.109	0.108	0.117	0.106
N.W./300-399	**MEDIAN**	0.110	0.110	0.108	0.089	0.089
N.W./>=400	**MEDIAN**	0.101	0.113	0.117	0.134	0.144
F.W./<100	**MEDIAN**	0.107	0.125	0.118	0.116	0.120
F.W./100-199	**MEDIAN**	0.132	0.138	0.127	0.127	0.127
F.W./200-299	**MEDIAN**	0.125	0.134	0.124	0.131	0.134
F.W./300-399	**MEDIAN**	0.107	0.116	0.135	0.124	0.166
F.W./>=400	**MEDIAN**	0.108	0.131	0.100	0.112	0.119

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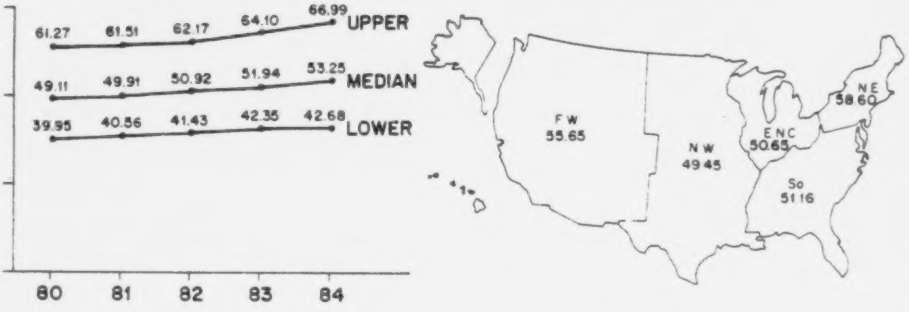
AVERAGE PAYMENT PERIOD RATIO


QUARTILES - ALL U.S.A.

1984 - REGIONAL MEDIANS

Discussion:

- The average payment period ratio provides a measure of the average time that elapses before current liabilities are paid. High values may indicate potential liquidity problems.

- During the five-year study period there has been a consistent upward trend in the value of this ratio. However, the 1984 increase was larger than prior years. This may be a result of the unusually large increase in days in patient accounts receivable which took place in 1984.

- There does not appear to be any significant regional difference in the values of the average payment period ratio.

- Hospital size does not appear to be associated with average payment ratio values.

- There are negative correlations between the average payment period ratio and the current ratio and the quick ratio. This implies that hospitals with low current and quick ratios are also likely to have high average payment period ratios.

1980 - 1984 COMPARATIVE VALUES FOR AVERAGE PAYMENT PERIOD RATIO

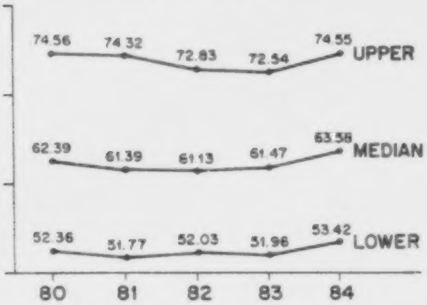
		1980	1981	1982	1983	1984
NATIONAL	LOWER	39.946	40.557	41.425	42.348	42.677
	MEDIAN	49.114	49.911	50.923	51.939	53.250
	UPPER	61.266	61.510	62.170	64.098	66.992
REGIONAL N.E.	LOWER	41.240	42.907	43.929	44.992	45.511
	MEDIAN	51.658	52.691	54.801	55.740	58.597
	UPPER	64.293	65.063	65.079	69.038	74.319
E N C	LOWER	38.922	40.064	40.708	42.311	42.868
	MEDIAN	47.660	49.052	49.682	51.358	51.650
	UPPER	59.767	58.655	59.252	62.380	63.305
SO	LOWER	38.499	38.891	39.905	[illegible]	[illegible]
	MEDIAN	47.414	46.100	[illegible]	[illegible]	[illegible]
	UPPER	57.689	57.391	[illegible]	63.182	[illegible]
N W	LOWER	36.963	38.031	[illegible]	[illegible]	[illegible]
	MEDIAN	45.660	[illegible]	[illegible]	48.560	[illegible]
	UPPER	[illegible]	[illegible]	56.790	58.254	[illegible]
F W	LOWER	44.613	[illegible]	44.387	45.614	[illegible]
	MEDIAN	[illegible]	54.083	53.815	[illegible]	[illegible]
	UPPER	[illegible]	67.370	67.456	[illegible]	[illegible]
BEDSIZE [illegible]	LOWER	40.534	40.973	40.632	[illegible]	[illegible]
	MEDIAN	51.973	53.536	52.430	[illegible]	[illegible]
	UPPER	69.793	[illegible]	[illegible]	[illegible]	[illegible]
100-1[illegible]	LOWER	[illegible]	39.829	[illegible]	[illegible]	42.908
	MEDIAN	[illegible]	49.150	[illegible]	[illegible]	52.251
	UPPER	59.642	[illegible]	60.808	[illegible]	[illegible]
200-299	LOWER	[illegible]	40.137	41.485	[illegible]	43.114
	MEDIAN	[illegible]	47.671	49.504	[illegible]	53.840
	UPPER	58.983	58.817	59.620	[illegible]	69.114
300-399	LOWER	[illegible]	40.820	40.988	41.985	[illegible]
	MEDIAN	[illegible]	49.775	49.849	51.295	[illegible]
	UPPER	[illegible]	60.550	62.386	62.358	63.476
>=400	LOWER	39.971	41.441	41.908	43.210	43.811
	MEDIAN	50.018	[illegible]	51.894	52.017	54.666
	UPPER	62.381	[illegible]	62.414	63.601	69.058

REGIONAL/BEDSIZE		1980	1981	1982	1983	1984
N.E./<100	MEDIAN	60.491	60.521	[illegible]	58.720	59.787
N.E./100-199	MEDIAN	48.940	51.007	[illegible]	51.831	52.982
N.E./200-299	MEDIAN	[illegible]	[illegible]	[illegible]	55.711	58.261
N.E./300-[illegible]	MEDIAN	52.999	54.231	54.924	58.027	59.160
N.E./>=[illegible]	MEDIAN	51.458	51.413	56.276	55.322	59.316
E.N.C./[illegible]100	MEDIAN	50.409	[illegible]	50.766	[illegible]	50.786
E.N.C./1[illegible]-199	MEDIAN	[illegible]	46.806	49.723	54.576	[illegible]
E.N.C./20[illegible]299	MEDIAN	47.494	47.653	47.597	47.402	[illegible]
E.N.C./300-[illegible]	MEDIAN	47.025	[illegible]	[illegible]	[illegible]	[illegible]
E.N.C./>=400	MEDIAN	[illegible]	49.348	51.659	[illegible]	[illegible]
SO/<100	MEDIAN	48.513	50.692	53.606	[illegible]	[illegible]
S[illegible]100-199	MEDIAN	49.574	50.704	50.578	[illegible]	[illegible]
SO/2[illegible]299	MEDIAN	[illegible]	41.236	[illegible]	49.337	[illegible]
SO/300-[illegible]	MEDIAN	44.731	[illegible]	[illegible]	[illegible]	49.299
[illegible]O/>=400	MEDIAN	49.171	47.184	48.815	[illegible]	51.325
[illegible]W./<100	MEDIAN	[illegible]	[illegible]	43.428	45.529	45.041
N.W./100-[illegible]	MEDIAN	44.760	44.760	47.001	47.042	46.727
N.[illegible]200-299	MEDIAN	[illegible]	47.007	49.999	55.978	58.689
N.W./300-399	MEDIAN	44.553	46.514	44.057	48.232	45.908
N.W./>=400	MEDIAN	48.065	47.414	52.285	50.155	54.600
F.W./<100	MEDIAN	57.000	55.438	54.024	53.118	54.181
F.W./100-199	MEDIAN	49.917	52.559	53.309	55.107	55.189
F.W./200-299	MEDIAN	53.458	52.320	55.800	55.214	57.659
F.W./300-399	MEDIAN	54.587	55.810	55.249	53.549	56.769
F.W./>=400	MEDIAN	50.451	52.339	52.696	54.852	55.086

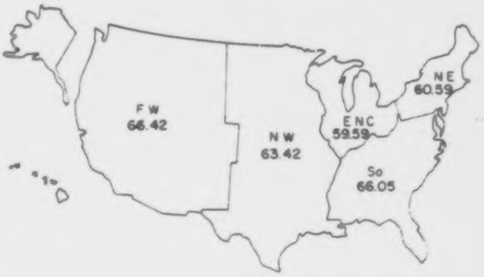
FAS

DAYS IN PATIENT ACCOUNTS RECEIVABLE RATIO

QUARTILES - ALL U.S.A.



1984 - REGIONAL MEDIANS



Discussion:

- The days in patient accounts receivable ratio defines the average time that receivables are outstanding or the average collection period.

- A sizeable increase in days in patients accounts receivable was experienced in 1984. The national median value increased by 2.117 days to 63.583. This increase has impaired the ability of the industry to increase their working capital cash reserves. Much of this increase probably reflects changes in payment policies by major third party payors. Further deterioration in receivables position may have an adverse influence upon liquidity if operating margins stabilize or fall.

- Far Western hospitals appear to have the longest collection periods. The length of the collection period in Far Western hospitals may explain their relatively poor acid test ratio position. East North Central hospitals have consistently had the best collection experience.

- There does not appear to be any relationship between size of the hospital and collection experience.

- Rural hospitals have consistently had longer collection periods. In 1984 the average rural hospital took 64.8 days to collect on accounts receivable while the comparable period for urban hospitals was 63.2 days. This difference has an effect on current asset turnovers and therefore return on investment.

1980 - 1984 COMPARATIVE VALUES FOR DAYS IN PATIENT ACCOUNTS RECEIVABLE RATIO

		1980	1981	1982	1983	1984
NATIONAL	LOWER	52.362	51.768	52.026	51.964	53.422
	MEDIAN	62.391	61.387	61.128	61.466	63.583
	UPPER	74.557	74.319	72.831	72.544	74.548
REGIONAL						
N.E	LOWER	51.800	51.263	50.485	48.937	51.984
	MEDIAN	61.119	60.334	58.522	58.804	50.587
	UPPER	71.061	71.543	70.519	69.966	72.242
E.N.C	LOWER	48.849	47.089	48.924	49.686	49.428
	MEDIAN	57.994	56.749	56.260	57.264	59.585
	UPPER	68.116	67.452	65.884	69.665	71.103
SO	LOWER	52.414	50.939	52.905	[illegible]	53.873
	MEDIAN	63.876	62.268	[illegible]	63.386	[illegible]
	UPPER	75.650	75.199	[illegible]	74.263	[illegible]
N.W	LOWER	51.786	52.233	[illegible]	[illegible]	52.352
	MEDIAN	[illegible]	60.471	[illegible]	[illegible]	[illegible]
	UPPER	[illegible]	76.493	[illegible]	[illegible]	[illegible]
F.W	LOWER	60.107	[illegible]	[illegible]	[illegible]	59.832
	MEDIAN	[illegible]	67.624	[illegible]	66.883	66.415
	UPPER	[illegible]	78.489	[illegible]	76.722	77.387
BEDSIZE						
<100	LOWER	53.846	52.858	54.261	53.428	[illegible]
	MEDIAN	65.310	64.244	65.146	[illegible]	[illegible]
	UPPER	81.041	[illegible]	78.879	[illegible]	[illegible]
100-199	LOWER	[illegible]	52.415	[illegible]	[illegible]	53.881
	MEDIAN	[illegible]	62.297	[illegible]	[illegible]	65.452
	UPPER	77.941	[illegible]	75.032	[illegible]	[illegible]
200-299	LOWER	[illegible]	51.449	51.519	[illegible]	[illegible]
	MEDIAN	[illegible]	60.477	59.704	[illegible]	[illegible]
	UPPER	71.489	71.489	71.346	[illegible]	73.183
300-399	LOWER	[illegible]	49.983	50.809	[illegible]	[illegible]
	MEDIAN	[illegible]	58.864	58.650	[illegible]	[illegible]
	UPPER	[illegible]	68.616	68.843	68.753	70.827
>=400	LOWER	[illegible]	51.841	51.722	51.242	53.408
	MEDIAN	62.364	61.709	60.059	60.362	63.415
	UPPER	73.660	[illegible]	71.186	70.222	73.814

		1980	1981	1982	1983	1984
REGIONAL/BEDSIZE						
N.E./<100	MEDIAN	59.676	[illegible]	58.121	56.738	56.969
N.E./100-199	MEDIAN	59.850	60.745	[illegible]	59.216	61.519
N.E./200-299	MEDIAN	62.240	[illegible]	60.149	63.080	65.339
N.E./300-399	MEDIAN	62.943	60.695	60.086	60.463	62.325
N.E./>=400	MEDIAN	60.429	60.122	57.160	57.080	59.705
E.N.C./<100	MEDIAN	[illegible]	[illegible]	57.018	[illegible]	65.391
E.N.C./100-199	MEDIAN	[illegible]	54.045	56.979	58.588	[illegible]
E.N.C./200-299	MEDIAN	59.495	58.923	56.120	56.640	[illegible]
E.N.C./300-399	MEDIAN	54.462	[illegible]	[illegible]	54.649	[illegible]
E.N.C./>=400	MEDIAN	[illegible]	57.261	56.790	[illegible]	[illegible]
SO./<100	MEDIAN	65.728	66.229	72.238	[illegible]	[illegible]
SO./100-199	MEDIAN	68.047	65.922	[illegible]	65.956	[illegible]
SO./200-299	MEDIAN	[illegible]	59.703	[illegible]	[illegible]	66.705
SO./300-399	MEDIAN	[illegible]	[illegible]	63.201	[illegible]	62.074
SO./>=400	MEDIAN	62.589	63.496	[illegible]	[illegible]	65.012
N.W./<100	MEDIAN	61.031	61.050	62.987	61.179	60.959
N.W./100-199	MEDIAN	62.350	60.822	63.242	62.773	64.301
N.W./200-299	MEDIAN	60.225	58.606	59.769	57.411	61.055
N.W./300-399	MEDIAN	56.844	57.860	57.594	57.860	60.249
N.W./>=400	MEDIAN	63.822	62.492	62.697	62.631	66.961
F.W./<100	MEDIAN	76.859	72.127	70.141	68.827	66.059
F.W./100-199	MEDIAN	71.018	67.842	67.582	67.227	67.649
F.W./200-299	MEDIAN	65.114	65.865	64.283	62.786	63.216
F.W./300-399	MEDIAN	65.058	65.487	66.053	61.390	63.056
F.W./>=400	MEDIAN	66.400	67.590	68.358	66.758	68.171

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	STANDARD & POOR'S RATING				
	AA+ AA AA-	A+	A	A-	BBB+ BBB BBB-
PROFITABILITY RATIOS					
DEDUCTIBLE	0.175	0.160	0.183	0.198	0.184
MARKUP	1.281	1.269	1.285	[illegible]	1.280
OPERATING MARGIN	0.057	0.048	[illegible]	0.027	0.021
NONOPERATING REVENUE	0.298	0.287	[illegible]	0.429	0.399
RETURN ON TOTAL ASSETS	0.065	0.060	[illegible]	0.040	[illegible]
RETURN ON EQUITY	0.134	0.130	[illegible]	[illegible]	[illegible]
REPORTED INCOME INDEX	[illegible]	0.978	0.962	0.928	0.955
CAPITAL STRUCTURE RATIOS					
EQUITY FINANCING	[illegible]	0.499	[illegible]	0.347	[illegible]
CASH FLOW TO TOTAL DEBT	[illegible]	[illegible]	0.178	0.136	[illegible]
LONG TERM DEBT TO EQUITY	0.585	[illegible]	0.971	1.443	[illegible]
FIXED ASSET FINANCING	0.594	0.634	0.781	0.892	0.917
TIMES INTEREST EARNED	5.574	4.348	2.783	2.129	[illegible]
DEBT SERVICE COVERAGE	4.653	[illegible]	3.161	[illegible]	[illegible]
ACTIVITY RATIOS					
TOTAL ASSET TURNOVER	[illegible]	[illegible]	0.831	0.826	0.773
FIXED ASSET TURNOVER	[illegible]	1.679	1.542	1.413	1.424
CURRENT ASSET TURNOVER	[illegible]	[illegible]	[illegible]	4.045	3.657
INVENTORY	[illegible]	[illegible]	[illegible]	81.163	65.465
LIQUIDITY RATIOS					
CURRENT	[illegible]	2.191	1.916	1.756	1.936
QUICK	1.655	1.881	1.623	1.393	1.677
ACID TEST	0.386	0.320	0.280	0.287	0.304
DAYS IN PATIENT ACCT. RE[illegible]	60.586	64.500	59.360	65.390	63.649
AVERAGE PAYMENT PERIOD	55.167	49.419	51.893	55.717	54.064
DAYS CASH ON HAND	18.242	15.637	14.240	16.086	16.408
OTHER RATIOS					
AVERAGE AGE OF PLANT	6.976	6.686	6.326	6.108	6.272
PRICE LEVEL TO HIST. DEP[illegible]	1.722	1.692	1.633	1.604	1.609
OPER. MARGIN(PRICE LEV. ADJ)	0.015	0.013	0.006	-0.007	0.000
RESTRICTED EQUITY	0.029	0.004	0.015	0.023	0.008
VIABILITY INDEX	0.792	0.783	0.905	1.219	1.058
REPLACEMENT VIABILITY	0.716	0.510	0.493	0.510	0.437
MEDIAN BED SIZE	510	469	305	282	152
NUMBER OF HOSPITALS	42	89	183	80	70

Senator **Durenberger**. Let me start with a question. If the four of you representing the provider side here could agree on a couple of suggestions to make to the inspector general, as the inspector general expands their survey of hospitals in this country, what do you think are the two or three most important things they ought to do somewhat differently the next time around?

Mr. **Owen**. I would like to start out, Mr. Chairman. It seems to me that just looking at a piece of the revenue is not sufficient because, even though the price for Medicare may have been higher than was established in the cost, the real test is what is the bottom line of revenue versus patient cost for the institution because we don't know what the indigent load is or what free care or what the winners or losers are on the other side. We would assume that if you won on Medicare, you are probably winning on the rest, but I think our statistics show that if you look at the total revenue, and you ought to—we don't have nearly the kind of profits that the inspector general showed.

It seems to me that you can't just take a piece out of the pie without looking at the whole pie. And I would suggest that that might be one of the things that they might look at as they evaluate the Medicare payment system and its effect on the total hospital operation.

Mr. **Kovener**. I would certainly echo Mr. Owen's sentiments there. The cost as calculated by the Medicare cost report have always been essentially irrelevant. The whole issue of comparing cost to PPS revenues is equally irrelevant. This system is not a cost-related system. And if you want to evaluate the fiscal health of the hospital field, you ought to look at the bottom line from all operations.

Mr. **Lipson**. I would like to add some other suggestions, too, sir. In the sample of the 892 hospitals, the only Northeast quadrant hospitals were those in Connecticut, which is an awfully small sample for the hospitals in the Northeast United States, and I think that needs to be expanded in a future study. I would also encourage that there be some identification between the difference of urban hospitals and suburban hospitals, with the suburban hospitals doing, we believe, far better than the hospitals in central cities. And, of course, we would encourage that that study be expanded in future years so that the continuing effects of the PPS system could be demonstrated.

Mr. **Howard**. I don't think I want to add much to those things except to say that geographic distribution is important, including all revenues is important, and including all costs if possible. If you look at the data that the inspector general has, he calculates the profit margin at 14 percent. He excludes depreciation and interest. I think that is inadequate. In my accounting book that used to be called contribution margin, I think—contribution to fixed cost, I think—and he should also take a look at return on equity if he is going to add it in—he should—if he is going to look at capital cost as a separate item, return on equity just simply ought to be taken out. But I just think he has to look at his methodology with respect to those 2,000 hospitals and make sure they are geographic as well as the right revenues are included.

Senator **Durenberger**. Well, I guess I am sitting here as part of an insurance company or a health plan, whatever you want to call it. And I am trying to buy my services differently, and I am trying to deliver. I've got a bunch of customers. I've got 36 or 32 million, or whatever the figure is, customers that have signed up with my company at some point in time, and every year there are millions more that are coming on line. And at least in part they have a choice as to whether or not they want to buy my product or something else, and a lot of them are sensitive about buying my product without buying something else to supplement it.

So they are showing a lot of nervousness out there about the way that I am buying on their behalf. And I don't want to lose those customers. If I ignore the realities, if this is put in there in 1965, it will stay forever. But I could lose those customers to something else if I cut down too far on the quality of service and so forth. So really what I am trying to design here, and annually trying to update, is a process by which I buy a set of services that will satisfy these 32 million people and their needs at a price that would be competitive with any other possible alternative. So the reason for having this hearing today and the bottom line is that the impression might get out that in the first year or so of PPS that we weren't very smart buyers.

And so, that is why I am happy that the inspector general is staying on the job on this issue. And what I am looking for then, since they are really operating on my behalf—I am getting the benefit of all their expenditures as an insurance company—are there ways to improve the base under this thing so that I don't do something rash in ratcheting that price down too far?

I guess what I have been hearing is that the base was pretty bad to begin with. Maybe Ron is right about all of these cost savings being rotten or maybe they didn't take into consideration the degree to which the cost of delivering hospital services has dropped so substantially in the last year or two. I mean, that is one factor we haven't talked about here too much. Or, Jack, you mentioned staff salaries or staff going down; the reality probably is that staff salaries have held, and you can't count on that forever. Having said all that are there some other suggestions we have for the inspector general?

Mr. **Howard**. The idea of the DRG's and how we would phase in. The DRG pricing system, in my way of thinking—and I am speaking of economic terms—is a price-fixing system. That is essentially what it is. It is no more than what we had back in 1973 except you have got one person setting the price.

The further away you get from 1984 and the date that you set those prices on, the less relationship that that price being set has to demand and supply into the health care marketplace. Now we agree that we should have phased this in over time which would allow, in my opinion, an orderly adjustment in what would take place in the system. We could have brought capital in in 1986; we could have continued this orderly adjustment probably to the end of the decade.

That means the system—the hospitals, the physicians, the HMO's—all would have perhaps handled this matter a little bit better and less impact, in my opinion, on quality. But what we have done is we have begun to ratchet it down on the basis of 1 year's data, more than likely, about 9 months' worth of data. We ratcheted it down because what took place is what Jack talked about. The hospitals began to manage their costs. You challenged us to manage our costs. So the first thing we looked at was that 60-percent item, which was what? People. We looked at it in two parts. We looked at it in terms of full-time equivalents, and we looked at it in terms of the way we were paying.

We began to make those adjustments. We began to look at alternative ways of purchasing. We began to do what you think is appropriate to run an efficient business. Now, if we had allowed that to continue, I think the margins would have begun to still trickle off. They would have still come down, but you could have phased in capital. It would have still moved ahead without any adverse impacts on the quality and quantity of care.

But, now, I am afraid that you could have some significant impacts on it in 1986 and 1987, and I shudder to think what we are talking about 10 years from today. But that is what I see happening, and what—how I feel—it would have worked.

Senator DURENBERGER. Jack?

Mr. OWEN. Let me just comment further on it. I agree with Sam 100 percent; he is absolutely correct. But you are sitting there as a president of a company with 32 million people out there, and you want to give them the best you could get. And going to just a flat average rate, with which you are always going to have winners and losers—if that is your concern, winners and losers—and winners seem to be more concerned than the losers—then that is going to continue as long as you continue to go in that particular way. If you really could put it back in the market system where we started our little debate on the economic values, when you deregulated the airlines, you didn't say that all airlines who fly from Washington to New York were going to have a fare of $39. It was up to each airline to set its own price.

And I think that if you really wanted to get the best, somewhere along the line you are going to have to have the ability of hospitals to compete on some kind of an economic market basket price, so that some hospitals will participate; some won't. Some you will buy services from both on quality and price; some you won't. But as long as we just set a flat price that keeps being ratcheted down, I wouldn't want to be president of that company either.

Mr. HOWARD. One further thing, suggestion, for the IG. I would like them to take a look at those rural hospitals. We have about 65 hospitals within HCA which are the only hospitals in the town, and a number of our hospitals are classified as rural. I believe that you will find the profit margins to be a bit less in 1985 than 1984. But more importantly, look at those third of the rural hospitals that he said lost money, and just look for the number of outlyers. It doesn't take but one or two outlyers a month, and you are in a loss position in a rural hospital.

Senator DURENBERGER. Let me ask a final question. We have other questions to submit to you all to be answered in writing for the record, but let me ask you about the issue of transfer of procedures from inpatient to outpatient looking at the last couple of years' history.

For all the reasons that we all know so well, the hospital industry now has incentives to move people from inpatient to outpatient; all the incentives move in that direction. We used to artificially create them by having an artificially low price for ESRD outside or for cataract surgery, or something like that, outside. Now the whole system pushes them from inpatient to outpatient, and one of the reasons that it does that is that you can transfer a lot of your expenses from the part A over to part B and still get cost base reimbursement. So I wonder if any of you are prepared to tell me to what degree that shift in hospitals inpatients this country has contributed to the appearance of part A profit over the last couple of years.

Mr. Kovener. There has been an extensive incentive to shift people to the least costly area of care so that the people that are left in the acute care setting are the most severely ill, and accordingly the most expensive. One of the problems in measurement of cost is the significant difference in the character of the patients that are served in the acute care setting today, both in contrast to the outpatient departments in those facilities and also the many free-standing facilities that have been set up to care for less severely ill patients.

So it is not just a shift between inpatients and outpatients in the hospitals themselves; it is a much broader issue than that.

Senator Durenberger. So are you acknowledging, Ron, then that part of this increase in so-called profit margin is due to the shift in expenses or cost base to the more reimbursable setting within the hospital industry?

Mr. Kovener. Quite to the contrary. I am suggesting that the cost as measured by the IG does not fully reflect the costs that are incurred for these more severely ill patients, because he is using old standards for measurement of cost that, as I said before, were never particularly relevant to the real cost of serving Medicare patients, and they are even less relevant when you have a different mix of patients.

Senator Durenberger. But can you have your cake and eat it too? And I don't know where your cake is here. I mean, I understand the hospital line is that as we move to more—move large parts of the population to more appropriate, less expensive, settings, we are left in our inpatient settings with a tougher patient, and you are saying that the IG has not adequately measured those expenses. I am saying that I am under the impression, right or wrong, that even though that is a more expensive setting for those particular patients, that you have taken—this industry has taken—I don't want you to get compensated twice, in effect. This is what is going through my head. You are moving some of those expenses out to get them reimbursed someplace else.

Mr. Owen. But we are not getting paid on a cost reimbursement system anymore, Senator.

Senator Durenberger. I understand that.

Mr. Owen. That was true in the old cost allocation system; that is what I think Ron is pointing out here. We moved off the old cost allocation system to a price for a product. The price for the product is the price for a DRG, and the price that has been established was based on some old 1983, 1982, and other costs that have been updated. But that has disappeared as far as a base per se; we are not being paid that way now.

In answer to how much of the shift has taken place, I don't know whether I can answer that because I don't know the reports coming back on how much—how many dollars—were spent under part B and how you separate what might be the hospital taking care of the patient versus the clinic down the street that is doctor owned that also comes out of part B. I don't know whether that is separated out so that it would be hard for me to answer that as to whether that shift really means that much.

Senator DURENBERGER. Well, let me get to the heart of the question then. Samuel H. Howard is the president-elect of the Federation of American Health Systems. It is no longer the Federation of American Hospitals. Yet this hearing is on hospital profits. Now we have got sort of a real time problem, which is that the IG has reported on hospital profits. The reality is that hospitals are no longer hospitals; they are health care systems, and wouldn't—back to my original question that started this off—wouldn't we and you and the IG all be better off if the IG took this sort of change in corporate circumstances and the paper flow that goes with expenses and looked at the reality that those left behind in the hospital are a tougher lot—if the IG could find some way to measure that, we would get a couple of good things.

We would get a more realistic profit picture for inpatient and outpatient, and that would help me get my outpatient surgery bill passed, because I wouldn't get these crummy estimates that I keep getting from CBO and OMB and HCFA. They have some kind of a—I don't know what they are doing, but they are trying to hide from all of us the profits that are being made by you hospitals. So I don't want to get too far into that. Anybody want to comment on that?

Mr. LIPSON. Yes; Senator, I think you get an incomplete answer from the inspector general on that kind of a question because a large proportion of the shift of services that are formerly inpatient and now outpatient are not being treated in the hospital-owned and operated facilities, so there may be part B reimbursement to physicians but not to hospitals. You simply would not get that kind of information out of hospital cost reports.

Senator DURENBERGER. I see. Well, maybe that is something—their chief folks are still hanging around here—maybe that is something we can——

Mr. KOVENER. The outpatient setting is the more cost-effective place to provide services and there should be financial incentives to provide services in that setting. So far the movement to fee schedules in the outpatient area, have not met that standard. It is appropriate that we look at ways to make it most financially advantageous for everyone to serve people in the most cost-effective manner.

Senator DURENBERGER. All right. Gentlemen, thank you all very much for your testimony and your continued cooperation. We appreciate it very much.

Our final witness today, I believe, is Mr. Robert Maxwell, who is a member of the board of directors of the American Association of

Retired Persons, and Robert, as you have guessed, is from the areas of Crossville, TN. We welcome you, Robert, and——

Mr. MAXWELL. Thank you, sir.

Senator DURENBERGER. Your statement, if we have it, will be made part of the record and you may proceed.

STATEMENT OF ROBERT MAXWELL, MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS, CROSSVILLE, TN

Mr. MAXWELL. I would like to do just that, Senator. My name is Bob Maxwell, and I am on the board of directors of the American Association of Retired Persons. I just received news that our membership has topped 21 million. We speak, though, not only for our membership, but we feel for all hospital patients in the country because the quality of health care being rendered to the Medicare patients is ultimately indicative of the quality of medical care for younger patients too.

My testimony this morning will focus on winners and losers so far under the PPS. My written statement details the association's major concerns with Medicare's Prospective Pricing System. I respectfully request that it be made part of the record.

Senator DURENBERGER. It will be made part of the record.

Mr. MAXWELL. Thank you, sir. The most important winner under PPS so far is the hospital insurance trust fund. In a sense, that makes all of us winners because the reduction in part A outlays adds a few more years of solvency to the hospital insurance trust fund. We think it should be solvent through the year 2000.

On the average, hospitals, too, have been winners under the PPS. The new payment system forced hospitals to streamline their operations, reduce the number of employees, and limit the rate of growth in their employees' wages. Moreover, hospital initiatives to reduce Medicare patients' length of stay and HCFA initiatives to limit inpatient admissions have resulted in improved operating margins for hospitals and significant savings for Medicare.

While hospitals on average have fared well under PPS, that is not to say that all hospitals are doing well under the new system, or that the favorable profit margin today will remain favorable tomorrow. The association is very cautious about the financial prognosis for hospitals under PPS for the future. The Government is saving money under PPS, hospitals are making money under it, but Medicare beneficiaries are paying more out of pocket for shorter hospital stays, if they can get in the hospital at all. And in too many instances, they are receiving poorer quality care.

Medicare beneficiaries are the big losers so far under the Prospective Pricing System. The increase in Medicare beneficiaries' out-of-pocket costs for hospital care have been dramatic. The part A deductible increased 23 percent this year, going from $400 to $492. It is estimated by HCFA to go up another 16 percent, to $572 by 1987. That is a whopping 43-percent increase in the deductible in 2 years.

In addition, because of the part A deductible serves as the basis for calculating the coinsurance on both extended hospital stays and skilled nursing home stays, increases in the deductible create a ripple cost-sharing effect. The large increase in the part A deductible is a function of the dramatic drop in Medicare patients' length of stay. Such an increase was not foreseen by analysts and policymakers considering the Prospective Pricing System in 1983. In contrast, the potential erosion in the quality of medical care for hospitalized Medicare patients was foreseen by many in 1983. Peer review organizations were created to guard against such erosion.

AARP and Medicare patients in this country are indebted to you, Mr. Chairman, for your leadership in creating the PRO's. Unfortunately, however, HCFA so far has failed to make quality review a serious priority of PRO's. As a result, the Medicare benefit has eroded, and the quality of care for too many Medicare patients has been compromised.

The new scope-of-work proposals for the second round of PRO contracts is an improvement in the area of quality. Nevertheless, a great deal of work in the area of quality remains to be done. Among the many recommendations stated in our written testimony is a recommendation that discharge planning be made a condition of participation for hospitals in Medicare. AARP believes that a coordinated discharge planning program is crucial to Medicare patients who are leaving the hospital quicker and sicker under the DRG system. Moreover, the continuity of quality care requires that Medicare patients' eligibility for postacute care services be certified prior to discharge. Because PRO's are predominantly physician-bound organizations, PRO's, not the fiscal intermediaries, should be making the initial determination of Medicare patients' eligibility for postacute care services.

Senator DURENBERGER. If I wanted to summarize your testimony, it is yes, there are profits still being made by American hospitals, but not by all of them.

Mr. MAXWELL. True.

Senator DURENBERGER. And the future looks even bleaker. And on behalf of 31 out of the 32 million—you have got a 31 million membership, but that includes me so——

Mr. MAXWELL. No, 21, Senator.

Senator DURENBERGER. Oh, 21.

Mr. MAXWELL. We only have two-thirds of them.

Senator DURENBERGER. On behalf of all those folks, your greater interest is in access to quality health care through a quality hospital system.

Mr. MAXWELL. True.

Senator DURENBERGER. So I hear you to say that the initial notion that hospital profits were up doesn't cause you to rush in here and say we have got to ratchet down on the DRG payments.

Mr. MAXWELL. Oh, sir, we have been fighting cost of care for 3 solid years. We feel that the work that has been done thus far in terms of the DRG system is great, but my concern is that regardless of the level at which we pay for it, we deserve quality care. My concern is that we may be overpaying for care that does not represent quality.

Senator DURENBERGER. I see. Very good, sir.

Mr. MAXWELL. So isn't it fair that, as in the marketplace, as we come to these organizations to serve us, regardless of who pays them, we deserve quality care?

Senator **Durenberger**. Mr. Christy, anything that should be added for the record of this hearing that you are aware of in light of the testimony you have heard earlier in the day?

Mr. **Christy**. No. Our testimony makes extensive recommendations for improvements in quality that should be addressed. We are looking forward to working with you and your staff in trying to modify the system this year so that we can feel assured that quality has the same priority as the profit margins for hospitals.

Senator **Durenberger**. All right. Well, gentlemen, thank you very much. Appreciate the association's continued interest in the subject and thank you for your testimony here today. That concludes this hearing.

[The prepared statement of Mr. Maxwell follows:]

TESTIMONY OF

ROBERT MAXWELL, MEMBER OF THE BOARD OF DIRECTORS OF

THE AMERICAN ASSOCIATION OF RETIRED PERSONS

Good morning. My name is Bob Maxwell and I am a member of the Board of Directors of the American Association of Retired Persons. On behalf of the over 20 million members of AARP I want to thank you for this opportunity to state the Association's views about some of the issues surrounding hospital profits under Medicare's new prospective pricing system (PPS). In six months PPS will complete the three year phase-in called for in the Social Security Amendments of 1983. Thus, it is useful at this point to evaluate how the new system has performed so far, and to consider changes that may be necessary before we go to a national rate for hospital services under Medicare.

My testimony this morning will focus on trust fund expenditures, hospital profits, beneficiaries out-of-pocket expenditures and the quality of medical care provided under the new payment system. I will conclude my remarks with proposals that AARP believes are necessary to stem the erosion of Medicare benefits under the new payment system.

WINNERS AND LOSERS

Recognizing that there is a serious lag in the availability of timely data and that the national data systems necessary to evaluate the effect of PPS on various interests are significantly lacking, it is, nevertheless, possible to roughly catagorize winners and losers under the prospective pricing system so far. The major winner under PPS is the Hospital Insurance (HI) Trust Fund. And in a sense that makes all of us winners because the reduction in Part A outlays adds a few more years of solvency to the trust fund. Government savings under PPS in 1984, for example, were over $2.2 billion. As a result, the HI Trust Fund is projected to remain solvent through 2000.

On average, hospitals too have been winners under PPS. The new payment system forced hospitals to streamline their operations, reduce the numbers of employees and limit the rate of growth in their employees wages. Moreover, hospital initiatives to reduce Medicare patients' length of stay and HCFA initiatives to limit inpatient admissions have resulted in improved operating margins for hospitals, and significant savings to Medicare.

While hopsitals on average have fared well under PPS, that is not to say that all hospitals are doing well under PPS or that the favorable profit margins of today will remain tomorrow. The Association is very cautious about the financial prognosis for hospitals under PPS.

The government is saving money under PPS and hospitals are making money under it, but Medicare beneficiaries are paying more out-of-pocket for shorter hospital stays (if they can get in at all) and, in too many instances, poorer quality medical care. Medicare beneficiaries are the big losers so far under the prospective pricing system.

The increase in beneficiaries' out-of-pocket costs for hospital care have been dramatic. Medicare beneficiaries have seen the Medicare Part A deductible rise steadily from $40 in 1966 to $400 in 1985. But few beneficiaries -- or policy makers -- were prepared for the enormous increase in Medicar's cost-sharing requirements that occurred this year when the Part A deductible rose by 23% from $400 to $492.

Beneficiaries derive small comfort from the knowledge that this dramatic increase results from the unhappy interaction of a fixed Part A deductible formula with a prospective payment system that has driven down the average length of stay by two days in two years. Nor is immediate relief in sight. HCFA now estimates that the Part A deductible will rise to $572 by 1987, an anticipated increase of 16% over the 1986 deductible and 43% over the 1985 deductible. In addition, because the Part A deductible serves as the basis for calculating the coinsurance amounts for both extended hospital stays and skilled nursing home stays, increases in the Part A deductible create a ripple cost-sharing effect.

Medicare beneficiaries are likely to see an increase in their out-of-pocket expenditures for Part B services, too. Although the freeze on physician fees, the participating physician program, and the increase in the number of physicians in practice seem to have moderated the rate of growth in out-of-pocket costs for physician services, the major shift to outpatient surgery and the end of the physician freeze will likely result in greater out-of-pocket expenditures for Part B services in the future. Indeed, beneficiaries' coinsurance liability for Part B services continues to rise at over three times the general rate of inflation, 1985 over 1984.

It must be noted that 21% of Medicare beneficiaries have no other form of protection against rising health care costs beyond their Medicare benefits, that is, they have neither private insurance nor Medicaid to absorb increases in Medicare's cost-sharing requirements. Coinsurance, deductibles, and physicians' fees exceeding Medicare's allowable charges must be borne entirely out-of-pocket by these 6 million beneficiaries.

QUALITY OF CARE UNDER PPS

The large increase in the Part A deductible is a function of the dramatic drop in Medicare patients' length of stay. The increase in the deductible was not forseen by analysts and policy makers considering the prospective pricing system in 1983. In contrast, the potential for erosion in the quality of medical care for hospitalized Medicare patients was forseen by many in 1983. AARP, testifying before this Committee in February, 1983, supported the prospective pricing system on the condition that it include a strong quality review component to guard against the powerful negative incentives for hospitals to skimp on care and to inappropriately reduce Medicare patients' length of stay.

AARP and Medicare patients throughout the country are indebted to you, Mr. Chairman, for your leadership in creating that quality review component. Unfortunately, however, HCFA so far has failed to make quality review a serious priority of peer review organizations (PROs). As a result, the Medicare benefit has eroded and the quality of care for too many Medicare patients has been compromised.

Under current law there is no program to review quality for an entire episode of illness, from admission through post-acute care. Thus, skilled nursing home and home health care patients are not assured of receiving quality care. Moreover, PROs do not have authority to review care in the ambulatory setting. Considering the shift of services from the inpatient to the outpatient setting, this lack of jurisdiction is a major loophole in the quality of care review process.

The absence of review of quality of care in the ambulatory and post-acute care settings represents important gaps in Medicare's quality assurance and monitoring program. But gaps in Medicare's quality assurance and monitoring program are reflected as much in the subtle details of the program, as in the program's omissions.

Though the most recent scope of work proposals are an improvement, the quality review requirements in PROs' current scope of work regulations are narrow, arbitrary and, in some cases, dependent upon data that is simply not available. HCFA requires PROs to pursue at least one quality objective in each of five areas. While the five areas identified by HCFA represent legitimate areas of concern over quality, they do not require the creation of quality assurance monitoring mechanisms at the places in the system where the incentives not to provide adequate, appropriate or quality services are greatest. Monitoring is essential to determining whether the services provided are adequate and appropriate, i.e., whether they represent an acceptable level of quality.

In addition to the weak quality objectives required under the PROs scope of work, the nature and emphasis of the PRO review process itself must be considered a gap in the Medicare quality assurance program. The PRO review emphasis is clearly on the financial issues of concern to HCFA and not on the quality of care issues that are important to beneficiaries. The emphasis is demonstrated in the funding of full time equivalents doing utilization review as opposed to quality of care review.

It is further demonstrated by the lack of funding for PROs to pursue cases of substandard quality. Pursuing such cases is costly because they involve a great deal of physician time and preparation. Moreover, such cases are almost always litigated by the hospital and physican(s) involved, thus requiring even more expensive professional review time. HCFA's failure to provide PROs with the resources to pursue these cases practically assures that they will not be pursued.

AARP believes that HCFA must reevaluate its approach to quality of care issues through the PROs. PROs must be allowed the flexibility and given icnentives to innovate -- to experiment with new medical review criteria, data profiling strategies, physician feedback mechanisms, physician training, and consumer education ideas.

Another gap in HCFA's quality assurance and monitoring program is in the area of data. Comprehensive, timely, and accurate data is essential to an effective review system. The scope and quality of PRO data will directly affect the ability of the PRO to maintain quality care, as well as control costs.

AARP questions the wisdom of forcing PROs to use claims data from Medicare fiscal intermediaries (FIs). Much must be done to improve the accuracy and adequacy of FI data for review purposes. AARP supports the development of a uniform collection and processing system that meets the needs of both FIs and PROs. Until such a system is operational, however, PROs must be permitted to secure access to information beyond Part A claims files.

Finally, the appeals procedures under the PPS provisions of Medicare do not provide a realistic or meaningful opportunity for beneficiaries to raise quality of care issues connected with discontinuance of a hospital stay.

Moreover, Mr. Chairman, HCFA has refused to allocate any of the savings from PPS to enhance access to post-acute care services. Indeed, HCFA has been aggressive in limiting access to post-acute care. For example, the financial cushion provided by Congress to encourage more skilled nursing facilities (SNF) to become involved in Medicare is slated by HCFA for elimination. This cushion, called the waiver of liability, is a presumption that a SNF acts in good faith if incorrect coverage decisions represents 5 percent or less of the provider's Medicare case load. If a SNF meets the presumption, then Medicare will pay for the uncovered services.

In a recent notice of a proposed rule, HCFA eliminates the waiver of liability by eliminating the presumption of good faith. The result of this change will be to further discourage SNFs from taking Medicare patients, thus making it even more difficult for post-acute care patients to get the skilled care that they need.

The elimination of the waiver of liability affects home health care providers too. Beyond the waiver problem, however, home health care providers face additional HCFA policies that have made access to home care more difficult. HCFA has created a form of denial that does not exist in Medicare law or regulations called "technical denials". A "technical denial" is the denial of payment for a home health visit based on the fiscal intermediary's (FI's) determination that the visit failed to meet a stautory or regulatory requirement, other than medical necessity. "Technical denials" are not subject to the waiver of liability and are not appealable by the home health provider. FIs make "technical denials" when they determine that a patient did not meet the "homebound" or in need of "intermittent care" eligibility requirements under Medicare's home health benefit. The interpretation of these terms is so restrictive that even the sicker patients coming out of hosppitals under the DRG system are having trouble qualifying for post-acute care services at home. Home health agencies are harmed by "technical denials" because they must absorb the cost of the services rendered.

These conflicting, contemporaneous policy directions reduce the availability of postacute care services necessary to accommodate Medicare patients under DRGs. As a result, Medicare patients are being discharged from hospitals into a no-care zone.

The current post-acute care situation for Medicare patients can be compared to the deinstitutionalization of mental hospital patients in the 1970s. In the 1970s it was considered good public policy to close mental hospitals and serve those patients in the community. The only problem was that a community-based mental health care system did not exist to serve them. As a result, the lucky deinstitutionalized patients ended up in nursing homes under Medicaid; the unlucky ones ended up on the streets or in the criminal justice system. The Congress must take remedial action to make sure that Medicare patients discharged from hospitals still needing care have an appropriate place to go.

RECOMMENDATIONS TO IMPROVE QUALITY OF CARE UNDER PPS

Strengthening the PROs

If PROs are to truly become guardians of quality, a great deal of work remains to be done to develop useful measures for evaluating quality of care. Moreover, the monitoring system as it now stands does not appreciate the system's incentives to undertreat; it falls short of having the capacity to identify compromises in quality care and is even less successful at correcting these compromises. With those shortcomings in mind, AARP recommends the following:

1. The commitment to quality of care review by the PROs must be demonstrated by HCFA. First, funding levels for the second round of PRO contracts must reflect a substantial broadening of the scope of review for quality of care. Second, the criteria for evaluation of PRO performance by HCFA must encourage and reward innovation in quality of care review and enforcement.
2. Generic quality screens must be incorporated into the standard review process to assist the PROs in the identification of quality problems. These quality screens should supplant the narrow, arbitrary, and difficult to validate quality objectives that are currently a part of the PRO scope of work. AARP is pleased to note that the most recent scope of work proposals require generic quality screens.
3. While the initial focus of quality review is on hospital inpatients, examination must not be limited to just the inpatient setting. Reductions in the length-of-stay, increases in patient transfers and greater use of outpatient services all point to the need for monitoring quality of care

in the ambulatory and post-acute care settings.

4. The monitoring mechanisms currently in place to detect premature discharge must be significantly broadened. The use of 7 days as the basis for review of readmissions is too short. Moreover, there is no monitoring of beneficiary need for emergency room services after a hospital discharge. AARP is pleased to note that the most recent scope of work proposals broadened the review to include readmissions within 15 days.
5. AARP supports legislation that would allow PROs to deny reimbursement for substandard care.
6. As a safety net for quality of care problems the Part A appeals process must be reformed to contribute more to the quality assurance and monitoring program. The unavailability of appeal rights until the patient places himself at financial risk is causing the patient to leave rather than challenge a denial of benefits. A basic commitment to quality care would require an appeals process capable of testing decisions to deny coverage on a case by case basis before benefits are terminated.
7. Finally, AARP will continue to press for a stronger consumer role in the implementation of the PRO program. A first step has been taken with the election of AARP-supported consumer members to the boards of seven PROs. The consumer-PRO relationship must be extended through board memberships, as well as a much more visible PRO effort to educate the beneficiary community about their rights and responsibilities

under the Medicare Program.

Discharge Planning

Discharge planning should be made a condition of participation for hospitals certified for Medicare and Medicaid patients. In coordination with the attending physician and hospital personnel the discharge planner should:

a. ensure the patient's readiness for discharge;

b. evaluate the appropriate discharge destination; and,

c. determine whether appropriate post-hospital care is available.

AARP believes that the continuity of quality care requires that Medicare beneficiaries' eligibility for post-acute care services be certified prior to discharge. In addition, since PROs are predominantly physician based organizations, PROs should make the initial determination of Medicare patients' eligibility for Medicare, SNF and home health benefits.

In those situations where post-acute care is necessary, but adequate, appropriate care is not available, the PRO must certify the patient for administratively necessary days (A.N.Ds.) in the hospital. PROs should review utilization of A.N.Ds. to ensure that the patient is discharged from the A.N.D as soon as adequate, appropriate post-acute care becomes available.

The Need for Data

Accessible, comprehensive data is essential to the tasks of both conducting quality review and evaluating its effectiveness. Therefore, AARP recommends the following:

1. PROs must be funded to support access to and integration of multiple data bases. AARP agrees with the American Medical Peer Review Association (AMPRA) that the PROs analytic potential can only be maximized by increased access to information systems beyond Part A claims data.
2. We must continue to find ways of presenting PRO-generated data in furtherance of the public interest in better informed consumers. AARP is not satisfied with the current data disclosure regulation. Public access to information is critical to making patient care choices and evaluating health care delivery.
3. HCFA must look closer at the so-called "Part B cost shift." The critical question to be answered is whether the savings in Part A result from a shifting of expenditures to Part B and to beneficiaries.

Research in Quality of Care

In the past, the commitment to quality health care was assumed by the presence of abundant resources. But skyrocketing health care costs made the need for cost containment pressing. The resultant DRG prospective payment system established a new set of financial incentives. Accompanying the incentives to reduce the hospital cost of each inpatient stay is the incentive to undertreat. Grappling with the real and potential quality of care problems under the new system brought to light the need to know more about quality of care. To help focus that light, AARP supports the following research agenda:

1. Measures to account for case complexity and severity must be refined so that they are easily used and sufficiently

descriptive of the differences between patients within the same DRG. Such refinement represents the next generation of quality review and must undergo experimentation for eventual implementation nationally.

2. Longitudinal studies of patient care. Patient health care outcomes must be monitored over time with the focus on such areas as functional status upon admission, changes in patient status as of discharge, the effect of shorter lengths of stay on discharge destination, and the post-discharge experience.
3. Measurements for quality of care should be studied to develop meaningful outcome measures. Specifically, the relationship of outcomes of medical care to the process of delivering care and the structural characteristics of providers should be examined.
4. AARP supports legislation (S.2001) that allocates a fraction of one percent of the Medicare Part A Trust Fund for research into medical practice variations. For the past several years, researchers have been tracking variations in the use of medical care and have begun to discover "systematic and persistent" variations in the standardized use rates for common surgical procedures as well as other services. These variations seem largely to be the result of what has been called "the practice style factor" which strongly influences not only the form of treatment undertaken, but the setting in which the treatment occurs. AARP recognizes the need for greater information about clinical outcomes and statistical

norms based on average performance.

STRENGTHENING CONSUMER INVOLVEMENT IN THE MEDICARE PROGRAM

AARP believes consumer involvement is an important factor in the development of the Medicare program. The Association is proud and enthusiastic about the beginning that has been made with consumer representation on the Boards of Directors of seven PROs, as well as the Board of Directors of the American Medical Peer Review Association. But consumer involvement is important in all aspects of the Medicare program, it is the foundation upon which public support is based. AARP believes that consumer involvement in the Medicare program must be statutorily assured by making Medicare subject to the Administrative Procedures Act. Consumers cannot fulfill their responsibility to Medicare if the policies, rules, and regulations governing Medicare can be made in secret and transmitted to Medicare's agents - carriers and fiscal intermediaries - without consumers' knowledge and ability to review and comment? Requiring HCFA to publish Medicare rules and regulations for public review and comment provides beneficiaries with the opportunity to influence the program before decisions about it are implemented. The publication, review and comment requirements of the APA will help keep HCFA from using nonstatutory or nonregulatory rules -- such as "technical denials" as a basis for denying Medicare benefits to beneficiaries who need them.

Elliot Richardson, when he was Secretary of Health, Education and Welfare, made a voluntary commitment to subject Medicare to the APA. This Administration has abandoned that commitment. It is time to revitalize that commitment by mandating that Medicare comply with the

APA.

CONCLUSION

Thank you again Mr. Chairman for your leadership in the cause of maintaining quality care under the Medicare program. My Association's interest in this area is not a selfish interest, an interest just in ourselves. We believe a simple truth binds the generations together in the quest for quality health care. That simple truth is this: The quality, or lack of it, of care under Medicare is ultimately indicative of the standard of care for most everyone else in our country. For Medicare is the flagship of the American health care system -- where it leads others follow. The issues of concern to Medicare beneficiaries today, will be the issues of concern to all health care consumers tomorrow.

[Whereupon, at 11:22 a.m., the hearing was adjourned.]

[By direction of the chairman the following communications were made a part of the hearing record:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

MAR 27 1986

Ms. Jean LeMasurier
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Ms. LeMasurier:

As requested by Mr. Edmund J. Mihalski on March 3, 1986, enclosed are answers to questions asked by Senators Packwood and Durenberger in follow-up to our testimony at the February 21, 1986 Subcommittee on Health hearing on "Hospital Profits Under Medicare's Prospective Payment System." Also enclosed are corrections in the transcript of our remarks during our testimony. These corrections are written directly onto the enclosed transcript.

If you have any questions, please call Steve Davis, of my staff, on 472-5270.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

Question P-1. Why were profits for Oregon hospitals in your study so high?

Answer.

Our survey was designed to compute Medicare profits or losses from Medicare inpatient services for a sample of hospitals during their first reporting period under the prospective payment system. We did not determine why these financial results occurred. Therefore, we cannot explain why the 34 Oregon hospitals we surveyed earned net average Medicare profits of about 18 percent, compared against the average profit rate of 14 percent for all 892 hospitals that were surveyed. The data we analyzed on Oregon hospitals indicates that:

- the 34 surveyed hospitals reported total Medicare inpatient revenue of $231.3 million, total Medicare inpatient costs of $188.2 million and net profits of $43.1 million.
- 31 hospitals reported Medicare profits ranging from $138,614 (4.6 percent) to $8,060,013 (39.4 percent).
- 3 hospitals reported Medicare losses ranging from $24,537 (-.9 percent) to $74,587 (-17.6 percent).

Question P-2. The AHA indicates that the Health Care Financing Administration has data on PPS payments and costs that could be used to measure profits directly attributable to PPS. Why didn't you use this data for your study?

Answer.

At the time of our review, HCFA did not have the hospital cost report data to measure hospital profits or losses during the hospital's first PPS reporting period. HCFA is currently accumulating this cost report information into a central file.

Question D-1. Your study shows that 19 percent of hospitals experienced losses. What were the characteristics of these hospitals, for example, were they in rural areas? Why do you think they were different from those with profits, e.g. were they inefficient?

Answer.

The results of our study of the 892 hospitals has shown a correlation between the size of the hospital (both physical bed size and Medicare revenue) and the profits/losses realized by the hospital. The larger the hospital and the more Medicare revenue received, the better chance the hospital had of making a profit. Conversely, a profile of the 19 percent hospitals (173 facilities) which experienced losses shows:

- The average bed size was 80.

- The average Medicare revenue was about $2 million.

- The average loss was 7.41 percent ($153,621).

About 72 percent of the losing hospitals in our study (124 of 173 hospitals) were rural hospitals. However, of the 391 rural hospitals in our study, only 32 percent realized a loss. The average loss of the rural hospitals was 7.79 percent. The other 267 rural hospitals earned a profit from their Medicare inpatient revenues in their first reporting year under PPS.

Question D-2. You stated that you are analyzing data from your broadened study of 50 percent of PPS hospitals. When will these results be available?

Answer.

We are in the process of analyzing data from over 2,000 hospital cost reports and these results will start being reported during April 1986.

Question D-3. If hospitals in the aggregate realized only 1 percentage point increase in profit on patient revenues in 1984, how could Medicare, which represents one-third of hospital revenue, average a 14 percent increase?

Answer.

We studied only Medicare inpatient revenues and costs during our survey. We did not gather data on the hospital's total operations which would also include non-Medicare revenues and costs. Consequently, we cannot reconcile the 1 percentage point increase in total patient profits reported by the hospital industry to the 14 average percent Medicare profit rate we computed. These two statistics suggest, however, that Medicare profits have subsidized non-Medicare losses incurred by the hospitals.

AARP

April 29, 1986

United States Senate
Committee on Finance
Washington, DC 20510

Attention of Jean LeMasurier

Dear Ms. LeMasurier:

Attached are answers to questions presented to Robert B. Maxwell, a member of the AARP Board of Directors, related to his testimony on February 21, 1986 at the Senate Subcommittee on Health Hearing on "Hospital Profits Under Medicare's Prospective Payment System."

Sincerely,

Jan Stefanov

Jan Stefanov, Ph.D.
Director
National Activities Office

/em

cc: Robert B. Maxwell

American Association of Retired Persons   1909 K Street, N.W., Washington, D.C. 20049   (202) 872-4700
Vita R. Ostrander *President*   Cyril F. Brickfield *Executive Director*

Testimony Before Senate Subcommittee on Health Hearing on "Hospital Profits Under Medicare's Prospective Payment System": Responses To Questions Presented to Robert B. Maxwell in Letter of Edmund J. Mihalski, C.P.A., Dated March 3, 1986.

P.1. You comment that the current data system does not provide accurate information on hospital profits in the aggregate or by individual category. The AHA has suggested that a reporting system be established to fill this gap. Do you think such a system will help assure that hospitals provide quality care?

Answer

The answer to this question depends to a large extent on the scope of the information system. An information system limited to hospital profits would not provide sufficient information upon which to make a confident decision about the quality of care a hospital provides. A comprehensive information system, however, in which hospital profits are but one part of a larger information system, could help assure that hospitals provide quality care. A system that includes information about utilization generally and by specific procedures, the rate at which patients acquire infections, the mortality and morbidity rates, and other kinds of information relating to the quality of care, would provide a powerful incentive for hospitals to be concerned about the care they provide.

P.2. One of the most important benefits to consumers resulting from PPS, which you did not mention, is that for the first time information will be available that Medicare beneficiaries can use to compare various hospitals -- for example, length of stay, mortality, infection rates, and so forth. California recently released such data. What is your reaction to the potential use of this information as a control on quality of care?

Answer

The Association believes that a comprehensive information system that includes information such as: length of stay, mortality, morbidity, and infection rates, has great potential for controlling the quality of care.

D.1. HMOs, which make a profit, know that in order to stay in business they must maintain quality of care. Now that hospitals are moving to a similar competitive position, they have the same pressures to meet or increase market share. Why would hospitals choose to keep excess profits at the expense of lower quality and their reputation in the community?

Answer

For the power of competition to animate the marketplace so that the concept of "lower quality" makes a difference to a hospital's reputation and, presumably, its income, would require a major change in the amount of information available about quality in the health care system. Most of that information has not been developed, much less reported in a manner suitable for consumers to base a meaningful decision. Perhaps over time hospitals choosing to keep "excess profits" would suffer enough to change their behavior. But given the current amount of information available to make a decision about the comparative quality of hospital care, and given the relatively low level of consumer experience in this area, it is unlikely that a hospital suffers from taking "excess profits".

BOB PACKWOOD, OREGON, CHAIRMAN

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WILLIAM DIEFENDERFER, CHIEF OF STAFF
WILLIAM J. WILKINS, MINORITY CHIEF COUNSEL

United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510

March 3, 1986

Mr. Jack Owen
Executive Vice President
American Hospital Association
444 North Capitol Street, N.W.
Suite 500
Washington, D.C. 20001

Dear Mr. Owen:

To follow-up on your testimony at the February 21, 1986 Subcommittee on Health hearing on "Hospital Profits Under Medicare's Prospective Payment System", Senator Durenberger would like you to answer the attached questions.

Your response should be typed on letter-sized paper and double spaced. To meet our printing schedule, please provide your answer no later than March 21, 1986.

Send your response to:

United States Senate
Committee on Finance
Attention: Jean LeMasurier
Washington, D.C. 20510

If you have any questions, Ms. LeMasurier can be reached at 202-224-4515.

Sincerely yours,

EDMUND J. MIHALSKI, C.P.A.
Deputy Chief of Staff
for Health Policy

Attachment(s)

EJM:crn

Senator Durenberger

D-1. Your data show that 52 percent of hospitals had negative patient margins in 1984. However, you also report that aggregate patient margins doubled from 1.0 to 2.0 percent the same year. Does this mean that 48 percent of hospitals made very large profits? What is the range of profits that we are talking about? Are you aware of any hospitals that realized so-called "windfall profits"?

D-2. You state that an unusually high percentage of hospitals in the 3 regions of the OIG study had "an unusually strong financial performance" that has not occurred in other regions. Why were these hospitals so successful?

D-3. Your data indicate that profit margins are leveling off in 1985. Aren't 1985 profit margins still substantially higher than 1983 margins, that is, before the implementation of PPS?

D-4. You suggest establishment of a system to monitor hospital profitability. How would you see such a system working?

(BH169)

ANSWERS FOR SENATOR DURENBERGER
HOSPITAL PROFITS HEARING

D-1 The data show that while 52 percent of hospitals showed a deficit in net patient margins for 1984, 48 percent of hospitals earned a profit during that period. Table 3, in particular, shows that approximately 21 percent of hospitals earned a profit in their patient services of only 0 to 3 percent. The full range of profits or deficits--distributed by bed size, rural or urban category, region, or type of ownership--is detailed in our testimony in Tables 3 - 9.

In the area of "windfall profits," there have been isolated reports of hospitals that have earned operating margins substantially above the average for reasons that are not entirely clear, even to the hospitals involved. It is clear, however, that this is not a situation that is likely to continue. Many of the economies achieved by hospitals in anticipation of the implementation of PPS are one-time savings, and will not be duplicated in later years.

D-2 In the first place, it is still not clear how individual hospitals within regions were selected for the report prepared by the IG. There are differences among hospitals in case mix, particularly by bed size, and there is some evidence to suggest that the DRG system does not account for severity of illness among patients treated in different hospitals.

D-3 Profits in 1985 were higher than in 1983, but, in fact, they are coming down. Again, economies achieved by many hospitals during the first year of PPS cannot often be duplicated, and many of the hospitals that earned favorable operating margins in 1984 or 1985 are seeing those margins diminish.

Further, 1983 should not necessarily be set up as a standard by which later years are measured. Under PPS, hospitals assume the risk for operating costs that exceed the DRG payments for particular patients. Rather than looking at arbitrary figures, it is important to identify reasonable margins for hospitals, given the increased risks of operation under PPS. Because of these risks, net patient operating margins higher that those earned in 1983 might be totally appropriate.

D-4 Operating margins are only one indicator of hospital performance. Another relevant factor, for example, is the size of the indigent care population treated by that hospital. The important question to be raised is whether Medicare is adding to the overall financial strain on an institution. Any future studies in this area should:

- structure valid samples;
- establish data collection processes that result in valid data collection in a uniform manner;
- be cautious about using the Medicare cost report itself because the nature of the cost finding techniques used by Medicare is at this time limited in its ability to reflect the costs of caring for Medicare patients.

We are particularly concerned with efforts underway by both ProPAC and HCFA to compute so-called "synthetic" cost estimates and to apply these estimates without validating their reliability and accuracy.

FROM THE DESK OF:
Mary R. Grealy, Esq.

Dear Jean,

Attached are our responses to the questions posed by Senators Durenberger and Packwood. Since Senator Durenberger's fourth question refers to a study done for us by ICF, Inc., we invited ICF to respond. Their responses are also attached.

Please contact me if you need additional information.

Federation of American Health Systems
1111 19th Street, N.W. • Suite 402
Washington, D.C. 20036
202-833-3090

QUESTIONS AND ANSWERS

SENATORS DURENBERGER AND PACKWOOD

3/21/86

P-1 As a payer, why should Medicare be concerned with a hospital's profit margin?

It shouldn't under normal circumstances. Hospitals should, however, be able to earn a competitive rate of return. If Medicare rates do not let hospitals earn a fair return, hospitals' ability to provide the quality level beneficiaries want will be impaired. When Congress enacted PPS it rejected proposals to limit the amount of profit which could be earned in order to provide ample incentive to reduce cost.

D-1 You state that hospitals will not be able to reduce their costs, especially employee costs, in the future. With changes in technology, and now financial incentives, much of patient care that previously was delivered in a hospital has been shifted to an outpatient setting. Why should Medicare continue to support what some estimate is a one-third oversupply of hospital capacity?

Cost reimbursement did subsidize unused capacity in the past. Medicare shouldn't support excess capacity and isn't now that it is paying on a per admission basis.

D-2 What was the experience of for-profit hospitals in 1984? What operating margins have for-profit hospitals reported so far for 1985?

Do you think your experience is different from other hospitals, such as the not-for-profits, and if so, why?

The experience of for-profit hospitals in 1984 is summarized in Exhibit One.

There are no data available yet on 1985 operating margins for investor-owned acute care hospitals as a whole. However, quarterly earnings estimates for major, publicly held hospital management companies show a breakdown in the trend of uninterrupted growth (Exhibit Two). The 1984 and 1985 pretax operating margins for the publicly held hospital management companies -- all operations -- were 10.5% and 9.2% respectively.

We do not think the after tax experience of investor-owned hospitals is significantly different from that of other hospitals.

D-3 AHA has suggested the need for a monitoring system on hospital financial performance. Do you agree with such a recommendation and how would you see such a system working?

The AHA does monitor hospital financial performance. There is no need for a government monitoring system.

EXHIBIT ONE

SUMMARY STATEMENT OF INCOME FOR INVESTOR-OWNED ACUTE CARE GENERAL HOSPITALS

($000,000) (1)

	1984		1983	
	Amount	% of Total Gross Patient Revenue	Amount	% of Total Gros Patient Revenue
ross Patient Revenue				
Routine Inpatient	$4,686	29.4%	$4,204	30.7%
Ancillary Inpatient	9,652	60.5	8,202	59.8
Inpatient Total	14,338	89.9		
Outpatient	1,614	10.1	1,306	9.5
otal Gross Patient Revenue	15,952	100.0	13,712	100.0
eductions from Revenue				
Bad Debt, Other	813	5.1	598	4.4
Contractual Allowances	2,760	17.3	2,588	18.9
otal Deductions	3,573	22.4	3,186	23.3
ther Revenue	159	1.0	92	0.7
et Revenue	12,538	78.6	10,618	77.4
xpenses				
Payroll	5,161	32.3	4,558	33.2
Supplies and Services (2)	4,575	28.7	4,019	29.3
Depreciation	599	3.7	417	3.0
Interest	678	4.3	464	3.4
otal Expenses Before Taxes	11,013	69.0	9,458	69.0
ncome Before Taxes	1,525	9.6	1,160	8.5
axes				
Federal	571	3.6	398	2.9
Property	96	0.6	99	0.7
Other, Excluding Payroll (3)	100	0.6	90	0.7
otal Taxes	767	4.8	587	4.3
et Income	$758	4.8%	$573	4.2%

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1) Financial data is reported for hospitals' fiscal years which need not be identical to calendar year

2) Includes supplies, lease costs, and other expenses.

3) Includes state and other taxes.

EXHIBIT TWO

QUARTERLY EPS PROJECTIONS

	1986	1985
American Medical International (AMI) -- (Aug.)*	$0.40-$0.45	$0.51
Hospital Corporation Of America (HCA) -- (Dec.)	1.05	1.16
Humana (HUM) -- (Aug.)	0.54	0.52
National Medical Enterprises (NME) -- (May)	0.52	0.49
Universal Health Services UHSIB -- (Dec.)	0.30	0.24

* fiscal year end

Response to Committee Questions

D-4

a. The data base used for ICF projections is based upon a data set from 1980, 1981 and 1982. In addition, more recently available data has been obtained from the 1984 PATBILL file and the 1984 American Hospital Association (AHA) survey.

The model data base requires a comprehensive set of data on individual hospital utilization, expenses, revenues, assets and liabilities. While these data were available for 1980-1982 from the American Hospital Association, they have not been made available since. Data for 1980-1982 were merged with 1980 and 1981 HCFA Medicare Cost Report data and with data from the annual Federation of American Hospital Survey of Investor-Owned Hospitals. These data were merged to provide additional information and to correct for non-response to the AHA survey.

In addition, the model has been updated using available data from the 1984 PATBILL file, which provides hospital specific information on Medicare utilization and case mix. Finally, we have merged in data on utilization from the 1984 AHA survey.

It is not meaningful to discuss the "range of error" associated with these estimates due to type of estimating methodology used. There are numerous variables which are estimated and used to produce model results, each with their own error range. Therefore, it is not possible to meaningfully estimate the error associated with any particular model output. For example, the model estimates a number of variables -- from wage rates to interest expense -- on the basis of a set of economic assumptions. Hence, the model will be at least as variable as the degree of possible deviation from that forecast.

b. We would expect overall margins to be slightly higher if it were possible to merge 1984 AHA data on revenues and expenses. However, we would not expect that margins on the inpatient side would greatly differ. Since the model focuses on inpatient care we would not expect model results to be greatly changed.

Hospital profit margins are different for inpatient and outpatient care and are estimated differently in the model. Medicare inpatient revenues are calculated on a case basis, while outpatient margins are calculated using historical information on margins.

c. The ICF study concludes that Medicare reimbursement is a predominant factor in determining hospital financial results. The reason for this is straightforward. Revenues from Medicare remain essentially stable, while both expenses and revenues from other sources increase over time. Because of this, Medicare reimbursement can be identified as a primary variable in forecasts of financial results.

Medicare reimbursement, of course, is not the only factor. Declining utilization rates also influence hospital financial performance.

4638N

d. The model uses a broad range of assumptions to produce forecasts. Some of these include:

- Number of beds and occupancy -- Each year, the model identifies hospitals which, because of high forecasted occupancy rates, may need to add beds. However, the model does not make assumptions regarding hospital closure. Therefore, while hospital inpatient capacity can increase, total capacity cannot decline. The additional assumption is made, however, that hospitals do not renovate, replace or modernize unused beds.

- Case mix -- The model uses HCFA published case mixes in 1981-1983. The 1984 PATBILL file was used to generate updated case mix figures which are used in 1984 and beyond. We assume case mix remains stable throughout the forecast period.

- Staffing -- The model calculates a base year wage per full-time equivalent employee. This rate is inflated over time using the labor inflation rate (see below). The number of FTE employees is estimated using a regression equation which has as input the number of beds, outpatient visits and net assets. Each year total staffing costs are estimated by multiplying the estimated number of FTE's by the wage rate.

- Wage costs -- Hospital wage rates are inflated using factors consistent with the Medicare Trustee's forecasts of increases in the hospital wage rate. The rates are shown in Table A-1 of our report and also included in Table 1 below.

It is impossible to tell how consistent model results are for 1985 and 1986 since there are no data currently available to evaluate this issue. In general, comprehensive audited data for hospitals lags 1-2 years. Hence, we would not expect audited 1985 data to be available until 1987 at the earliest.

Table 1

Inflation Assumptions for Hospital Wages

Year	Percent Change
1981	12.3
1982	11.2
1983	7.4
1984	5.5
1985	4.9
1986	5.9
1987	7.4
1988	7.4
1989	7.2
1990	7.0

e. The model forecasts hospital financial performance for each of the nation's community hospitals. Model results can therefore be aggregated in any way specified by the user to look at the financial performance of specific hospital groups.

The study conducted for FAH focused on current law projections and therefore did not consider the Administration's capital proposal or potential legislative changes.

f. There are no comprehensive valid data available on hospital diversification, and therefore revenues from these ventures are not included in the data base. It might be anticipated that incorporation of these data would increase margins. In fact we suspect that this is the major reason why AHA reported margins are higher than what might be anticipated.

We would expect that estimates of overall margin might be higher if these data were incorporated. However, the focus of the study was whether inpatient revenue covered inpatient costs, and we would not expect our conclusions regarding this to be greatly different even if these data were incorporated.

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United States Senate

COMMITTEE ON FINANCE
WASHINGTON, DC 20510

March 3, 1986

Mr. Samuel H. Howard
President-Elect, Federation of
American Health Systems
1111 19th Street, N.W., Suite 402
Washington, D.C. 20036

Dear Mr. Howard:

To follow-up on your testimony at the February 21, 1986 Subcommittee on Health hearing on "Hospital Profits Under Medicare's Prospective Payment System", Senators Packwood and Durenberger would like you to answer the attached questions.

Your response should be typed on letter-sized paper and double spaced. To meet our printing schedule, please provide your answer no later than March 21, 1986.

Send your response to:

United States Senate
Committee on Finance
Attention: Jean LeMasurier
Washington, D.C. 20510

If you have any questions, Ms. LeMasurier can be reached at 202-224-4515.

Sincerely yours,

EDMUND J. MIHALSKI, C.P.A.
Deputy Chief of Staff
for Health Policy

Attachment(s)

EJM:crm

Senator Packwood

P-1 As a payer, why should Medicare be concerned with a hospital's profit margin?

Senator Durenberger

D-1 You state that hospitals will not be able to reduce their costs, especially employee costs, in the future. With changes in technology, and now financial incentives, much of patient care that previously was delivered in a hospital has been shifted to an outpatient setting. Why should Medicare continue to support what some estimate is a one-third oversupply of hospital capacity?

D-2 What was the experience of for-profit hospitals in 1984? What operating margins have for-profit hospitals reported so far for 1985?

Do you think your experience is different from other hospitals, such as the not-for-profits, and, if so, why?

D-3 AHA has suggested the need for a monitoring system on hospital financial performance. Do you agree with such a recommendation and how would you see such a system working?

D-4 The following questions are on the ICF Inc. study that you discussed in your testimony.

a. How current are the data underlying the ICF projections? What is the range of error surrounding the projections?

b. How would the projections in the ICF study for 1987-1991 be different if they were adjusted for actual data, such as 1984 data from the AHA which shows margins of 6.2% on total operations and 2.0% on patient care, and actual 1984 Medicare spending of $5.8 billion as reported by H.C.F.A.? Are hospital revenues, costs and profit margins different for inpatient compared to outpatient services?

c. The ICF study concludes that, "the changing pattern of Medicare reimbursement rules is the predominant factor determining hospital financial results." Yet Medicare pays only one out of every three dollars hospitals receive. Why is Medicare's effect so significant?

d. What are the study assumptions on:

- o Number of beds, occupancy rates, and changes since 1981?
- o casemix, and changes since 1981?
- o staffing costs, and changes since 1981?
- o changes in wage costs.

Would you say that the ICF projections for 1985-6 have been consistent with actual performance to date?

e. Are data on financial performance (past and future) available for the following different kinds of hospitals?

- o proprietary hospitals
- o public hospitals
- o private non-profit hospitals
- o teaching hospitals

- non-teaching hospitals

- hospitals with different bed size ranges?

What is the impact of the Administration's proposed FY 87 capital proposal and the estimated PPS update of 2% on each of these groups of hospitals?

f. Does the ICF model have any data on the number of hospitals that have diversified by opening insurance subsidiaries, home health agencies, or other ventures and if so, are revenues from these ventures included in the model?

Do estimates of financial performance change when projections of revenues from these ventures are factored in?

(BH167)

HFMA

HEALTHCARE
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March 18, 1986

United States Senate
Committee on Finance
Attention: Jean LeMasurier
Washington D.C. 20510

Dear Ms. LeMasurier:

In response to Edmund Mihalski's letter dated March 3, HFMA is pleased to respond to the questions from Senators Packwood and Durenberger.

Question P-1: It is true that overall costs in hospitals are increasing much less rapidly than has occurred in recent years. It is also true that occupancy is lower. These circumstances reflect the prompt, decisive action by hospitals and physicians in response to the new incentives of the prospective price setting (PPS) system. Patients being served currently tend to be more severely ill and, accordingly, more costly to serve. Furthermore, hospitals' fixed cost must be absorbed by fewer patients, thereby increasing the cost to each patient actually served.

No business, including hospitals, can provide services for less than their cost. An industry that has been blessed with high profit margins might be able to respond to these pressures by holding prices steady or reducing them and making up the difference out of profit. Hospitals, as the data in the material provided demonstrates (and in contrast to the inaccurate impression left by the Inspector General's memorandum), have never had large profit margins and, accordingly, do not have an opportunity to absorb inadequate payments out of profits. In price competitive circumstances, an enterprise might lower prices in order to retain market share. However, Medicare is not operating in a price competitive manner, but rather rates are imposed on providers. Because of the lack of profit or competitive pricing, hospitals have no reasonable alternative other than to recover, in their charges, the economic needs related to the provision of services, curtail quality, such as failing to make new technology available, or cease operations, thereby, reducing patients' access to services.

Question D-1: The median price level adjusted operating margin increased from a loss of 9/10 percent in 1983 to a loss of 1/10 percent in 1984, according to data in HFMA's Financial Analysis Service (FAS). The lower quartile improved from a loss of 3.4 percent to a loss of 2.7 percent and the upper quartile from 1.7 percent to 3 percent. Thus, even with 1984's improved financial performance, over half of hospitals in the FAS database were still operating at a price level adjusted loss. The median operating margin increased from 2.1 percent in 1983 to 3.1 percent in 1984. The lower quartile operating margin increased from 3/10 percent to 7/10 percent between the two years. The upper quartile values increased from 4.7 percent to 6.0 percent. In all cases, there is improvement but none of these amounts would seem to be properly characterized as a "substantial profit."

Question D-2: HFMA's FAS is based on annual audited financial statements. Accordingly, it is too early for a sufficient amount of information to be available for fiscal years ended in 1985.

Question D-3: HFMA believes that the federal government's public policy role requires that it give attention to the fiscal health of the healthcare industry. Adequate financial resources are essential to assure access to all who need services and to achieve the continued progress in technology and quality that all citizens deserve. We believe attention to this public policy role, which includes consideration of the fiscal health of the industry, is of greater importance than the government's role as a purchaser of healthcare services for segments of the population.

Attention to financial performance does not require a new "monitoring system," however. There is ample industry data available from the American Hospital Association for Congress to fulfill this public policy role. Operating margins and other measures of profitability and liquidity of institutions with average Standard & Poor's bond ratings might be an appropriately impartial basis for evaluating financial performance. Median financial performance of hospitals should qualify them for an "average" bond rating. The industry is still substantially below such a standard.

If we can provide additional information on any of the above, please let us know.

Sincerely,

R. R. Kovener
Vice President

RRK/dvw

Senator Packwood

P-1 You suggest that pressures to reduce Medicare payment levels will mean that hospitals will have to charge more to other payers or cut services. Since overall costs are down, and there are an increasing number of unfilled beds, don't you think it will be difficult for hospitals to sustain existing rates, let alone increase them to other payers?

Senator Durenberger

D-1 Your data show that hospital profits increased 35 percent in 1984. Since you indicate that many hospitals had an operating loss, does this mean that many had a substantial profit? Please elaborate on the range of experience.

D-2 Do you have any information on profit margins in 1985? Do you see the level declining as suggested by AHA?

D-3 AHA has suggested the need for a monitoring system on hospital financial performance. Do you agree with such a recommendation and how would you see such a system working?

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OF COUNSEL

March 13, 1986

Ms. Jean LeMasurier
United States Senate
Committee on Finance
Washington, D.C. 20510

Dear Ms. LeMasurier:

Enclosed please find my answers to the written questions submitted by Senators Packwood and Durenberger in connection with my testimony at the February 21, 1986, Subcommittee on Health hearing on "Hospital Profits Under Medicare's Prospective Payment System." A copy of the senator's questions is also enclosed.

Sincerely yours,

Nathan Stark

Nathan J. Stark

Enclosure

Senator Packwood

P-1. The AHA suggested the need for a financial monitoring system to track hospital profits. What is your opinion of this proposal?

Senator Durenberger

D-1. Hospitals have the potential to realize "windfall" profits by shifting costs to other parts of the health care delivery system, or by cutting care below the minimum necessary to assure quality. Because the hospital does not have financial risk for the whole Medicare benefit, the safeguards in the HMO example you cite may be inappropriate. What alternative to rate regulation would you propose to assure that hospitals provide the appropriate level of service?

ANSWERS -- NATHAN J. STARK

P-1. I don't think the PPS program was conceived as guaranteeing any particular profit level for hospitals, and therefore I don't believe the government needs to establish a system to monitor the level of hospitals profits to insure the program is working. Obviously, the government should be informed if its Medicare reimbursement policy is causing large segments of the industry to go broke, but I am confident that if that happens the government will be promptly informed by industry. Should the profitability of hospitals become relevant to any particular problem under the program, the industry is also capable of providing government policy-makers with current information on profits, and I think the industry would be willing to provide that kind of information voluntarily.

I would add, however, that if the government's Medicare reimbursement policy is ultimately going to be significantly influenced by what kind of profits or surplus policy-makers think the industry is making, then in that case it certainly would be important for the government to have access to up-to-date, accurate information on the level of hospital profits. Policy decisions based on incomplete or inaccurate information invariably lead to trouble.

D-1. I am not so sure that hospitals will easily be able to realize windfall profits by shifting costs to other parts of health care delivery system. One way to shift costs is to increase the cost burden on the privately insured sector; however, in my opinion the insurance companies are simply not going to permit hospitals to shift costs from Medicare to them. Another way to shift costs is to accelerate the discharge of patients to secondary care facilities. This kind of cost shifting will create a quality of care issue, and there are already regulatory and institutional checks in the system which are intended to prevent the quality of care from falling below minimum standards. These include the peer review system, which should be monitoring quality, and periodic reviews by the Joint Committee on Hospital Accrediation, which can withdraw its certification if quality falls below acceptable levels. From a competitive standpoint, hospitals must also be concerned with their own standing in the community. They cannot afford to get the reputation as a second rate hospital by cutting care below minimum standards. In this context it is worth noting that ultimately it is not up to the hospitals to determine what treatment is required or when patients should be discharged. Those decisions are made by the patient's physician who is also concerned with his or her reputation for quality of service as well as with the possibility of malpractice claims respecting decisions that do not meet minimum standards.

It is true that HMOs are obliged to provide their enrollees a broader range of service than are hospitals under Medicare and that hospitals may therefore not have all of the motives that HMOs have to maintain their level of quality of health care. Each one, however, assumes responsibility for a specified level of care and each therefore has the same concern that if the quality of its service falls below an acceptable level it will lose business, if not incur liability for malpractice. While hospitals could perhaps theoretically save costs by prematurely shifting patients to other segments of the health care delivery system I don't think hospitals will escape criticism for poor quality care if they engage in this sort of cost shifting.

Nor do I think that rate regulation, at least as I understand that term, will necessarily assure that hospitals do provide the appropriate level of service. Rate regulation assures only that the regulated entity earns a reasonable rate of return on investment. To assure an appropriate level of service, rate regulation must be accompanied by some form of quality control regulation.

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HOSPITAL
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April 11, 1986

United States Senate
Committee on Finance
Attn: Jean LeMasurier
Washington, D.C. 20510

Dear Ms. LeMasurier:

Please accept my apology for the delay in getting our responses to the questions of Senator Packwood and Senator Durenburger. Our answers to their questions are attached. If I can provide any additional details, please call me at 682-1581.

Sincerely,

Steve Lipson

Stephen H. Lipson
President

JHL/sli
Enclosure

UNITED STATES SENATE

COMMITTEE ON FINANCE

SUBCOMMITTEE ON HEALTH

Responses to Questions

District of Columbia Hospital Association (DCHA)

Senator Packwood:

P-1 Did the hospitals you represent receive an adjustment for medical education costs in 1984? What was the impact of these payments on profit margins? How will proposals to change medical education impact inner city hospitals?

Yes, several hospitals in the District of Columbia received an adjustment for medical education costs. For the hospitals' first year under the prospective pricing system, direct and indirect medical education payments contributed $32.8 million to inpatient receipts of District hospitals that have teaching programs. Total inpatient receipts for these hospitals for the same period amounted to $631 million. Therefore, the average impact on the bottom lines of these hospitals was approximately 5%.

While the impact of proposals to reduce medical education payments would vary from hospital to hospital, it would be disastrous to the financial stability of several District of Columbia hospitals and probably to many inner city teaching hospitals and their patients throughout the United States.

If federal budget cuts are implemented, DCHA estimates that between $9 million and $27 million could be lost to District hospitals which serve 35,000 Medicare patients. When losses to the five D.C. hospitals which do the most teaching are calculated separately, they are estimated to range from $400 per case to $1200 per case. These losses are calculated considering all federal cuts, not just medical education cuts, but they illustrate that the central city teaching hospital could become an endangered species.

Senator Durenberger:

D-1 Average hospitals reduced the rate of their expense growth by 5.6 percent in 1984. How did your expenses change in 1984?

Between 1983 and 1984, the aggregate rate of expense growth for the non-federal hospitals in the District of Columbia was 7.0%. Between 1984 and 1985, the aggregate rate of expense growth was reduced to 2.9%. This substantial decline demonstrates the formidable efforts being made by the hospitals to contain costs.

D-2 How did you make up the $150 loss on each Medicare patient?

The loss figure indicated in the testimony from DCHA refers to the difference between the cost of treating the Medicare patient and the actual payment received for that patient. This is a conservative estimate. Contractual allowances, the differences between the prices charged and the payment, are not part of this figure.

Currently Medicare, Medicaid, and uncompensated care losses are made up in part by those private insurers which pay full charges, and by Blue Cross/Blue Shield which in the District pays hospitals according to a cost-plus formula (less than charges). This transfer of payment responsibility from insufficiently funded plans to private plans is commonly referred to as cost-shifting.

Hospitals are becoming less able to shift enough costs to continue to recover losses on government sponsored (and unsponsored) patients. Private group purchasers of care, such as health maintenance organizations, independent practice groups, and large employers have begun to utilize their purchasing power to negotiate lower charges for their enrollees. The short-term result is that those hospitals with large numbers of government sponsored patients and unsponsored patients must shift these costs and therefore cannot reduce their charges enough to be competitive with those hospitals serving smaller numbers of these patients.

The long-term result is that private hospitals serving large numbers of government sponsored patients and unsponsored patients will be forced increasingly to send those patients to public hospitals, thus overloading those systems. Ultimately, some hospitals will close unprofitable services, or perhaps close entirely. The risk is greatest to those hospitals which serve the most Medicare, Medicaid and unsponsored patients -- those hospitals which our communities can least afford to lose. In all cases, access to care becomes a major concern for all patients -- private as well as government sponsored ones and unsponsored ones.

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cha California Hospital Association
1023 12th Street P.O. Box 1100 Sacramento, CA 95805-1100 916/443-7401

March 5, 1986

The Honorable Bob Packwood, Chairman
Committee on Finance
SD 219 Dirksen Senate Office Building
Washington, D.C. 20510

Subject: Health Subcommittee Hearing, Senator David Durenberger, Chairman; The Profits Realized by American Hospitals Under the Medicare Prospective Payment System.

Dear Chairman Packwood:

On behalf of California hospitals, the California Hospital Association is hereby submitting comments for the record of the hearing before the Senate Committee on Finance Health Subcommittee regarding profits realized by hospitals under the Medicare Prospective Payment System (PPS).

We are aware that the genesis of the Subcommittee hearing was the recent news coverage of hospitals' financial performance. Those results are based on an audit by the Health and Human Services Inspector General (IG) of 1984 Medicare cost reports for 892 hospitals. This audit showed these hospitals earn an average 14 percent profit under PPS. However, CHA, like the American Hospital Association, feels the IG study is insufficient in scope, and its findings are in sharp conflict with more comprehensive survey data. The American Hospital Association data show an overall patient margin of 2.2 percent in 1984. In California for the same year, the average operating margin was 0.65 percent. For the first three-quarters of 1985, compared to the same three-quarters for 1984, the rate was 1.53 percent. The California data base includes all hospitals reporting to an independent agency of the state government.

Over the last few years, the financial health of California hospitals has improved somewhat, as evidenced by the figures in the following table.

Average Operating Margin of California Hospitals[1]

1982	1983	1984	1985 (Jan.-Oct.)
-0.87%	-0.80%	0.65%	1.53%

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[1] State of California, California Health Facilities Commission

The modest overall margins experienced in the last two years are inconsistent with the 14 percent Medicare profit figures reported by the IG. Assuming the IG's findings are correct, it appears they only apply to the hospitals studied, rather than the entire industry. The reliance of the study on the first cost reports filed after the enactment of PPS is likely to have produced a sample of hospitals that is not representative of the industry. All California public hospitals as well as many large urban institutions entered the PPS at a later date because of their July 1 cost reporting period starting date.

More important, regardless of their actual level, Medicare margins in the first year of prospective payment are not likely to be sustained. Faced with the sudden transition from Medicare cost reimbursement to prospective payment, hospitals implemented many drastic cost-cutting measures, including significant staff reductions. The first year prospective Medicare rates were determined primarily by the hospitals' historical cost experience. As rates are less reflective of institution-specific circumstances each year, with an eventual transition to purely national rates, California hospitals are faced with decreasing Medicare payments. This trend was accelerated by the current freeze in prospective rates and may become worse in future years because of the anticipated Gramm-Rudman-Hellings cuts.

It is unlikely that hospitals can reduce costs at the recent pace without seriously impairing the quality of care. It is also unlikely that hospitals could make up Medicare losses from other sources. The Medicaid program (Medi-Cal in California) is about to enter a fourth year of contracting with hospitals on a prospective basis. The contract rates essentially have been frozen at the first year level. The private sector also has moved away from cost reimbursement and is aggressively pursuing alternative financing and delivery systems. This environment presents a serious challenge to an industry which must preserve quality of care despite dwindling resources.

While we are sensitive to your concern, it is clear to us, based on much better data than that which the IG used, that there is no evidence the margins of California hospitals approach the margins claimed in the IG report.

We would be happy to answer any questions you or your staff may have. Please don't hesitate to contact us.

Respectfully,

John H. Ferman
Senior Vice President

JHF:cb
cc: Senator David Durenberger
C. Duane Dauner, President, CHA
Jack Owen, Executive Vice President, AHA

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March 4, 1986

SENATE FINANCE COMMITTEE
Room SD219
Dirksen Senate Office Building
Washington, D.C. 20510

Gentlemen:

Enclosed is written testimony relative to hospital costs under the Medicare Prospective Payment System.

If you require additional information, please feel free to contact me.

Sincerely,

K. Rand Dykman

K. RAND DYKMAN
Executive Director

KRD:nb

HOSPITAL COSTS UNDER THE MEDICARE PROSPECTIVE PAYMENT SYSTEM

Thank you very much for this opportunity to present written testimoney relative to hospital costs under the Medicare Prospective Payment System.

It is understandable that members of Congress are concerned about the cost of health care and specifically about the hospital component considering significantly overstated reports of estimates of profit margins under Medicare prospective pricing. There is, however, one segment of the hospital industry which has experienced significantly increased profit margins and this increase is at the expense of other segments of the industry. The area in which windfall profits have been experienced is related to graduate medical education reimbursement.

For purposes of this discussion, I will define hospitals in three categories: medical school related university hospitals (major teaching); hospitals with affiliated graduate medical education programs (lesser teaching) and non-teaching hospitals. In addressing graduate medical education and its reimbursement through the prospective pricing system, one must consider two major components: direct and indirect medical education costs (1986 projections - $1.3 billion direct, $1.4 billion indirect). Lesser teaching hospitals have been reimbursed for indirect teaching costs on the basis of a formula which considers the number of full-time equivalents of interns and residents related to the number of beds which is then divided by a factor of .1 and multiplied by a factor of .1159. This last factor was doubled during the development of the DRG reimbursement system which had two immediate effects: lesser teaching hospitals were significantly over paid for teaching expenses and since, the process was "budget neutral", when one segment of the industry is over paid at least one other segment is underpaid. Considering the negative impact of DRG payments on the profit margins or absence of profit margins of the non-teaching hospitals, it is clear which segment has been underpaid. Major teaching hospitals,-with much greater educational cost related to University overhead have not experienced the significant overpayments of the lesser teaching hospitals.

The windfall profits provided to one segment of the industry further jeopardize the other two segments because the added financial strength created by those profits put the lesser teaching hospitals at a significant competitive advantage. Once again th reimbursement system has been engineered to obscure efficiency and inhibit the competition the system was intended to generate.

Adequate reimbursement for graduate medical education is important not only to the health care industry but also to society as a whole. Strong, well financed, graduate medical education is essential to the continued enhancement of the level of health care in the United States, however, that education should be reimbursed at an appropriate level and cost effective elements of the hospital industry should not be placed in financial jeopardy by subsidizing windfall profits in the name of "budget neutrality".

○